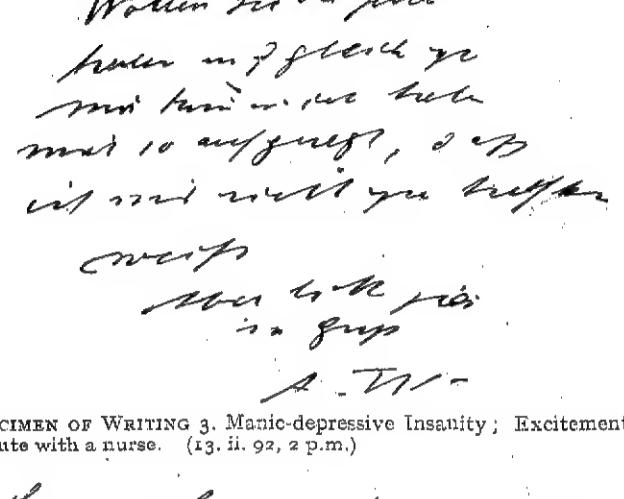
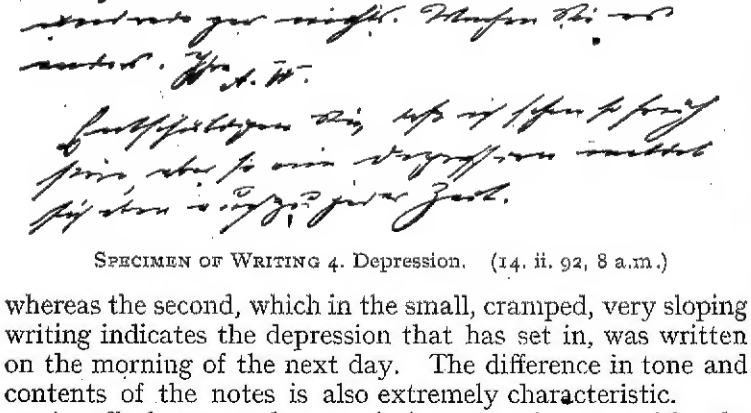
enterprise, a flower in his buttonhole, a cane in his hand, and smoking two cigars at the same time, the other time in bed, with rigid features straining anxiously. The specimens of writing 3 and 4 likewise show well the change of states. The first with the careless, disconnected, very much shortened stroke was written in excitement after a dispute with the nurse;



SPECIMEN OF WRITING 3. Manic-depressive Insanity; Excitement after a dispute with a nurse. (13. ii. 92, 2 p.m.)



SPECIMEN OF WRITING 4. Depression. (14. ii. 92, 8 a.m.)

whereas the second, which in the small, cramped, very sloping writing indicates the depression that has set in, was written on the morning of the next day. The difference in tone and contents of the notes is also extremely characteristic.

Ascaffenburg made association experiments with the patient portrayed here. In the percentage of clang

associations they furnished a clear picture of the gradual disappearance of manic excitement and the transition to the state of depression. They are reproduced in Fig. 42;

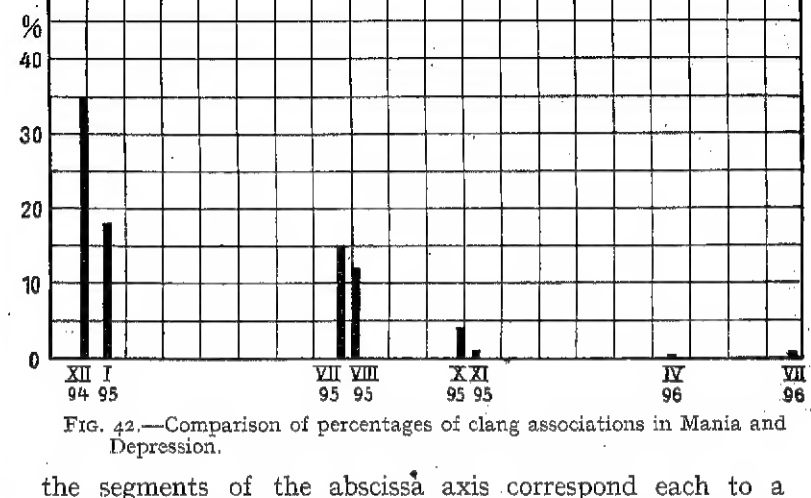


FIG. 42.—Comparison of percentages of clang associations in Mania and Depression.

the segments of the abscissa axis correspond each to a month. With the disappearance of manic excitement, which at the beginning of the experiment had already lasted more than a year in the most severe form, the number of clang associations falls quite regularly, and completely returns to normal shortly before the discharge of the patient, which took place in December 1895. About the end of the same month an unusually profound depression with extremely severe inhibition set in, which made association experiments impossible. The two next experiments in April 1896 furnished not a single clang association, the one in July gave one per cent. We were able to follow the transition from depression to mania, as Fig. 43 shows, by means of perception experiments with the aid of the pendulum tachistoscope. It is seen here how in the course of about a month the number of correct perceptions, already small at the beginning, decreases steadily while at the same time the number of in-

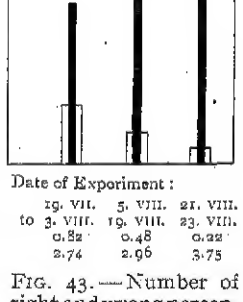


FIG. 43.—Number of right and wrong perceptions in the transition from Depression to Mania.

□ Correct perceptions.
▬ Mistakes.

correct perceptions increases in far greater measure. At the same time also the patient, who at first was still distinctly depressed, had become definitely manic.

The course of the body-weight in two double attacks of a female patient with slight hypomania and simple inhibition

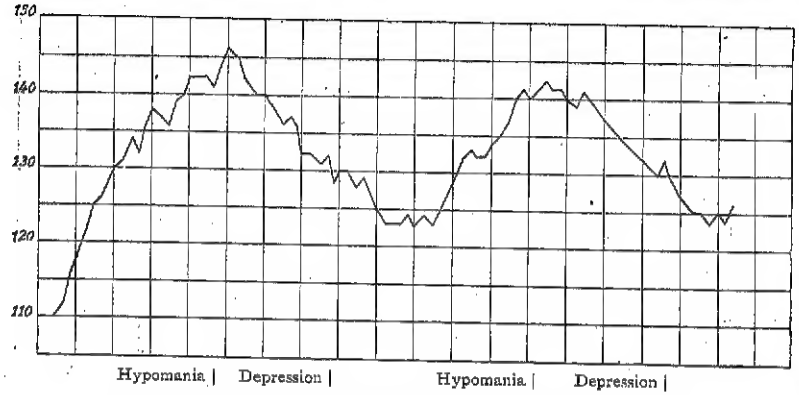


FIG. 44.—Manic-depressive Insanity; two double attacks.

is shown in the curve Fig. 44. We see how it increases during excitement and again falls accurately with the commencement of depression. Also in the different behaviour of the pulse curve the contrast of the two morbid periods is marked with surprising distinctness.

CHAPTER IX.

PROGNOSIS.

THE prognosis of manic-depressive insanity is favourable for the individual attack. For long the prospect of recovery especially in manic excitement has been considered very good; with this the circumstance may be connected that mania is preferably a disease of youth. In fact one may, even after very long duration of excitement or depression with reliable diagnosis, still hope with great probability for complete restoration to health. In especial one must not let oneself be deceived by the mental inertia which apparently exists often during mania or after severe raving, and which is usually only the expression of inhibition of thought and later, as a rule, completely disappears, although slowly.

On the other hand in every case which belongs to manic-depressive insanity we must reckon with the possibility that the disease will be repeated several times or even very frequently. How great this probability is, cannot at present be stated with certainty. The following up of a large number of cases throughout life could alone settle the point. As those who have only been ill once, frequently avoid further observation, while those with frequent relapses represent a very conspicuous part of institutional life, it may readily be thought that in general we are inclined to over-estimate the danger of a return of the malady. If we only were able to decide with greater certainty whether the isolated case belonged to manic-depressive insanity or not, it might turn out that in a not altogether inconsiderable number of cases there was only one attack, or, as one may also perhaps express it, having regard to the pauses extending over thirty years or more, that the patients died without a relapse taking place. In any case it must be taken into account that the length of the intervals in almost 20 per cent. of the cases amounts to ten years and over.

As appears from our former comparison, the cases running their course in the two forms show the greatest tendency to frequent repetition. The commencement of the malady with

a double attack will, therefore, make the prospects for the future appear more unfavourable. A series of attacks following one another without interruption and changing repeatedly in colouring must be regarded as specially critical. It often signifies the development of permanent circular fluctuations of state, as in our examples 9, 14, 15, 16, 18. But the morbid process may also, as examples 12 and 13 show, again come to a standstill, and there may be pauses of many years. In the years of involution one must be prepared for the return of former attacks; often just at this time there is a considerable series of attacks similarly or variously coloured, as in our cases 2, 3, 9, 14, 16. The time of the return, if a certain regularity has not already appeared, cannot up till now be even approximately foretold. In general frequent return of the attacks with short pauses may be certainly reckoned on in the cases beginning very early and without external cause. If the malady, however, first appears later and in conjunction with far-reaching injuries, perhaps in confinement, relapses do not usually follow so quickly.

How far the clinical peculiarities of an attack to some extent allow reliable conclusions to be made as to the further form of the morbid state, is up to now still quite obscure. Perhaps, however, with very extended observation some prognostic rules may be got, although the incalculable influences of personal predisposition and conduct of life will always be important sources of error. In the meantime one may, perhaps, say that hypomania is most frequently connected with simple inhibition, while severe acute mania is generally followed by strongly marked depression with delusions and a tendency to stuporous states. Clouding of consciousness, hallucinations, and delusions seem, when they appear, readily to accompany both phases of the disease.

Even when manic-depressive insanity lasts a very long time, the psychic state of the patients in the intervals does not usually suffer any considerable injury, if the attacks themselves run a mild course. On the contrary there are many of those patients who in the free intervals do very good, indeed distinguished mental work. Kahlbaum has compared these slighter forms of the disease as "cyclothymia"[1] with

[1] Hoche, Über die leichteren Formen des periodischen Irreseins, 1897; Wilmanns, Die leichten Fälle des manisch-depressiven Irreseins und ihre Beziehungen zu Störungen der Verdauungsorgane, 1906; Römheld, Sommers Klinik, ii. 449; Jelliffe, *American Journal of Insanity*, 67, 661.

the more severe forms leading to weakmindedness, which he called "vesania typica circularis." This distinction has, however, only a limited practical value, in so far as the cyclothymics cannot in the ordinary sense be regarded as "suffering from mental disorder," and, therefore, are liable to an essentially different judgment and treatment. But fundamentally it obviously concerns everywhere the same morbid processes. That is made evident not only by the lack of all sharp boundaries between cyclothymia and manic-depressive insanity, but also by the circumstance, that we often enough can observe in the same morbid course along with severe attacks of depression or acute mania numerous slight cyclothymic fluctuations of mood also.

Violent and long-lasting attacks of manic-depressive insanity may likewise end with complete restoration of the former psychic personality, if they only occur once in a lifetime. On the other hand with increase of attacks, in certain circumstances perhaps also with very severe single attacks extending over many years and in advanced age, there exists the greater or less danger of the development of a psychic decline. Perhaps in the other direction we must make the development of lasting changes responsible for the unfavourable course of the disease. The states of weakness, which appear in such cases, invariably let the after-effects of past attacks be recognized. Many patients remain permanently quiet, depressed, uninterested, stand about in corners with dejected or anxious appearance, fold their hands, lament in a low voice, when questioned give hesitating, monosyllabic, but sensible and usually appropriate answers. They are inactive, irresolute, timid, have to be forced to everything, resist energetically when much interfered with. Frequently also the residua of depressive delusions still persist; the patients call themselves the devil, ask for forgiveness, for a mild punishment, are afraid that they will be sent away, that they will have to remain there for ever.

The antithesis of this group, which might be called "chronic melancholia," is made up of those patients, which Schott[1] has brought together under the name of "chronic mania." Here manic features dominate the picture. The patients are in general sensible and reasonable, and perceive fairly well; memory and retention are also fairly well preserved. On the other hand there exist increased distractibility, wandering and desultoriness of thought, a tendency to

[1] Schott, Monatschr. f. Psychiatrie, 1904, 1.

silly plays on words, poverty of thought. The patients have no understanding of their state, consider themselves perfectly well and capable of work.

Mood is exalted, but no longer exultant, enjoying activity, but silly and boastful; occasionally it comes to flaring up without strength or durability. The finer emotions are considerably injured. The patients show little interest in their relatives, do not shrink from making coarse jokes about them, do not trouble themselves about their affairs, do not worry at all about their position and their future, at most once in a way they beg without energy for discharge. Only the coarser enjoyments, eating, drinking, smoking, snuffing, still arouse in them vivid feelings, further the satisfaction of their personal wishes and wants; everything else has become to them more or less indifferent. At the same time the patients develop an activity often very disturbing, without, however, more serious restlessness. They like to interfere in everything, act as guardians to the feebler patients, snarl at them, take from them what they want. They collect all possible rubbish in their pockets, make a mess with it all round about, rub and wipe things, adorn themselves with rags and scraps of ribbon, talk more than their share, swagger, try to gain for themselves all possible little advantages. They can meantime scarcely, or not at all, be employed for profitable work on account of their unsteadiness and indifference as well as their inclination to all sorts of mischief. Schott is of the opinion that severe hereditary taint specially favours this issue; also the residence in an institution continuing often for decades with its blunting and narrowing influences, as well as approaching age, might have a certain influence. In spite of their smaller share in general in manic-depressive insanity men are said to suffer somewhat more frequently from this decline.

At this point we have to mention in a few words another group of cases, in which the psychic decline reveals itself in continual, abrupt fluctuation between lachrymose anxiety, irritability, and childish merriment. States of this kind sometimes appear to be developed from a continuous accumulation of short circular attacks. The original delimitation of individual attacks becomes more and more obliterated, so that it finally becomes impossible to characterize the state at any given moment. A kindly word suffices to make the patient sitting in apparent distress smile pleasantly, clap his hands, sing, dance about, but just

as quickly do tears, self-accusations, or silent brooding again follow, which then perhaps gives place to a jocular outburst of abuse, all without any deep-seated feeling, desultorily changing and easily influenced. Left to themselves the patients appear for the most part indifferent, without desire, poor in thought, they display no specially striking colouring of mood; they are able to employ themselves diligently.

Finally, the question would still have to be raised, whether in certain circumstances some of the mixed states might not also issue in a peculiarly coloured decline. To myself that appears probable for depressive excitement. But it would be conceivable, that for example manic stupor also or depressive mania might once in a while take such a course. Occasionally, I have come across cases, which seemed to suggest such an interpretation, but further investigation in the field of observation furnished by large institutions are necessary before it will be possible to form a definite opinion about this question.

The prognosis of manic-depressive insanity is to a certain extent made uncertain by its relations to *arteriosclerosis*. I have already directed attention to the fact that the disease by no means rarely develops first in the years of involution and even in still more advanced age, sometimes just after an apoplectic seizure. On the other hand numerous experiences are forthcoming which give evidence for the premature appearance of arteriosclerotic changes in our patients. Albrecht reports that in fifty-four cases he could demonstrate arteriosclerosis eighteen times, and of these more than the half were between fifty and sixty years of age, six were almost fifty. What view should be taken of this connection remains for the present obscure. It might be possible that the frequent and great fluctuations of the blood pressure and of the vascular innervation, which appear in the disease, signify injury to the vessels. If one prefers the assumption of chemical causes, one might think that the same poison, which engenders the alternation of psychic states, affects also the arterial walls, just as one thinks of the relation between syphilitic, that is paralytic, vascular change and the corresponding cortical diseases; thus the appearance of circular attacks, when arteriosclerosis already exists, is more readily comprehensible. For this view epileptic attacks also might not be without significance; they occur, indeed, seldom, but now and then they are observed. I saw a patient, fifty-two years of age, who did not suffer either from

alcoholism or syphilis, suddenly collapse with apoplexy after repeated, severe epileptic attacks in the fifteenth year of a manic-depressive insanity. Only in the last weeks of his life did the symptoms of arteriosclerosis appear distinctly. His mother also had died of apoplexy.

When in the course of manic-depressive insanity arteriosclerotic changes are added or, what also occasionally happens, fairly severe senile changes, psychic states of weakness may be developed, which obliterate the original morbid picture. I have repeatedly seen patients, who had suffered from a series of attacks without any injury to their psychic capacities worth mentioning, become demented in advanced age and indeed in the well-known form of arteriosclerotic or senile weakmindedness. As we know cases enough of the opposite kind, in which manic-depressive patients suffer no kind of psychic loss at all in spite of advanced age, we must possibly always connect the appearance of a definite dementia of that kind with the addition of a fresh, more or less, independent disease. Pilcz is of the opinion, that the development of dementia is essentially related to the existence of old brain scars. That would probably only happen so far as these are the expression of a morbid process, which is still capable of progression, as syphilis or arteriosclerosis.

Issue in *death* is not very common in manic-depressive insanity. It may be caused by other diseases of various kinds, by simple exhaustion with heart failure (collapse) in long continuing, violent excitement with disturbance of sleep and insufficient nourishment, by injuries with subsequent blood-poisoning, and by fat emboli in the lungs in consequence of extended bruising or suppuration of the subcutaneous connective tissue. Very stout people with insufficient functional capacity of the heart muscle are decidedly endangered in severe manic attacks. Finally outside of institutions suicide also claims a considerable number of victims, especially in the slight cases apparently not yet or no longer in need of institutional treatment. With suitable shelter and supervision this serious danger can be very much restricted, but unfortunately not always excluded with absolute certainty; in particular, premature discharges now and again lead to bitter experiences. In elderly people apoplectic attacks occasionally occur. As yet there is nothing certain to report in the *morbid anatomy*.

CHAPTER X.

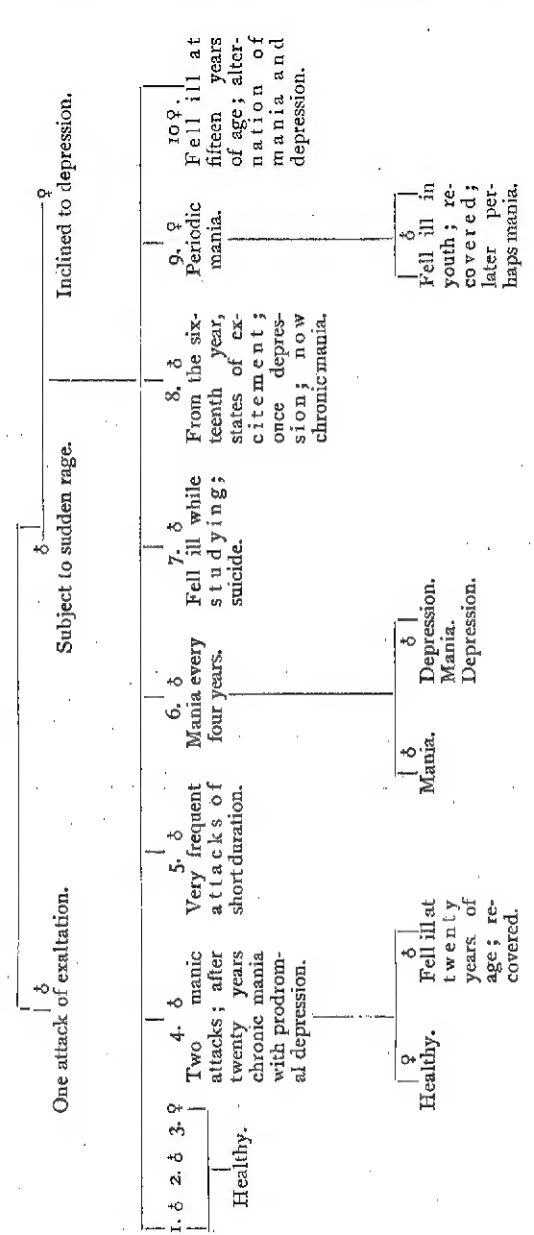
CAUSES.

MANIC-DEPRESSIVE insanity in the sense here delimited is a very frequent disease. About 10 to 15 per cent. of the admissions in our hospital belong to it. The causes of the malady we must seek, as it appears, essentially in *morbid predisposition*.

Hereditary Taint[1] I could demonstrate in about 80 per cent. of the cases observed in Heidelberg. Walker found it in 73.4 per cent., Saiz in 84.7, Weygandt in 90, Albrecht in 80.6 per cent., and in the forms with numerous attacks still somewhat more frequently. Taint from the side of the parents he found in 36 per cent. of the cases, in the last-named forms in 45 per cent. The values got in Munich are considerably lower on account of the much less complete knowledge of the previous history. But still *mental disease* or *alcoholism* could be demonstrated in the parents in one-third of the cases, the latter alone in something over 10 per cent, of the cases. Here, as in Heidelberg, I had the experience that cases of manic-depressive insanity in parents or brothers and sisters were disproportionately frequent. Further, I very often found suicide, which points in the same direction. Lastly, the occurrence of psychopathic personalities in the family was also frequently reported, of whom likewise so many have certainly to be reckoned to the domain of the malady discussed here. On the other hand, epilepsy, arteriosclerosis, and, as far as an opinion could be formed, dementia præcox also do not seem to play any part worth mentioning in the hereditary series. Vogt reports that in 22.2 per cent. of his cases mental disease existed in the father or the mother, in 35.2 per cent. in the brothers and sisters, against the corresponding values of 12.2 and 15.3 per cent. in other forms of insanity. Kölpin has communicated a very instructive pedigree, which is reproduced on the following page.

It is seen that of ten children of the same parents, who probably were both manic-depressive by predisposition, no

[1] Fitschen, Monatsschr. f. Psychiatrie, vii. 127.



fewer than seven fell ill in the same way; of the five descendants of the second generation four have already fallen ill. Rehm has instituted investigations about the children of manic-depressive parents. He found among forty-four children from nineteen families signs of psychic degeneration in 52 per cent., particularly in 29 per cent. abnormal emotional predisposition, by preference in the depressive sense. Bergamasco established that among 157 patients from fifty-nine families 109 belonged to manic-depressive insanity; the remainder were divided among pellagrous insanity, dementia præcox, senile dementia, epilepsy, paralysis, hysteria.

Evidence for the assumption of *inherited syphilis* was present in only a few cases. The *endowment* of our patients was in 62.2 per cent. of the cases, in which information was to hand, said to be good or very good. There were 13 per cent. who had been good scholars, 10.7 per cent. poor. Therefore, although among the patients there were a few who might be considered weakminded, still in general their intelligence seemed to be rather above the average. That *artistic* predisposition is relatively frequent, was repeatedly indicated; here relations probably exist with the liveliness and mobility of the emotions. Symptoms of *physical degeneration*, especially malformations, distortions, smallness or hydrocephalic bulging of the cranium, infantilism, are often present; of many patients it was reported that they had suffered from infantile convulsions, and for long from nocturnal enuresis, and had learned late to walk or to speak.

Age.—The distribution of the first attacks of the malady with regard to age are shown in the diagram (Fig. 45). In rare cases the first beginnings can be traced back even to before the tenth year. Friedmann[1] describes in young persons manic or depressive attacks, which run a mild course, and which are often incited by external causes, or series of such; he calls these "mild forms." Stuporous, delirious, and somnambulistic states are frequent in these; sometimes complete and lasting cure is said to take place, which indeed could only be established with some certainty after decades. Liebers has described a case of mania lasting six months in a boy under five years of age.

The greatest frequency of first attacks falls, however, in the *period of development* with its increased emotional excitability between the fifteenth and the twentieth year. But

[1] Friedmann, Monatsschr. f. Psychiatrie, xxvi. 36,

in the next decade also the number of attacks is still very great, and only gradually decreases after the thirtieth year. This fall is interrupted between the forty-fifth and fiftieth year by a fresh rise, whose after-effect is seen in the slower descent of the numbers up to the fifty-fifth year. Obviously the influences of the years of involution here play a part. Isolated attacks begin first in very advanced age. Petrén observed a case which began at the age of eighty and at eighty-eight still presented no symptoms of senile dementia.

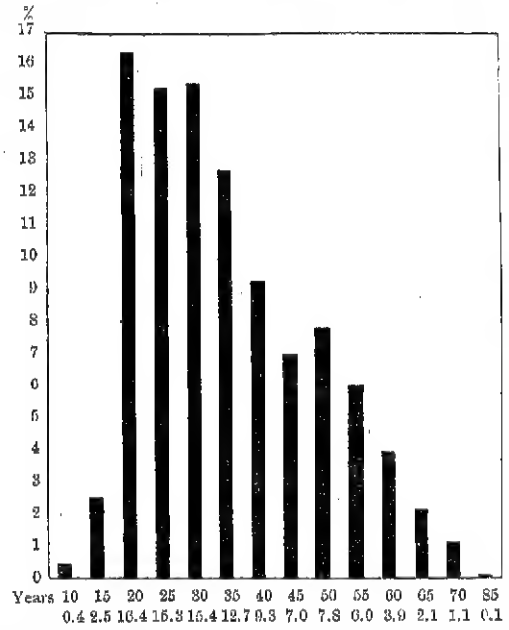


FIG. 45.—Distribution of the first attacks of Manic-depressive Insanity (903 cases) with regard to age.

A further view of the significance of age is afforded by Fig. 46. Here the distribution of the cases beginning at the different ages is given according to their clinical colouring. Purely manic and depressive cases were kept distinct and also those cases in which manic and depressive morbid phenomena were conjoined or were fused to well-marked mixed states. Only states fully developed one way or the other or mixed were taken into account, but not the admixture of isolated transitory morbid symptoms of opposite kind in an otherwise unequivocal clinical picture. From these considerations the noteworthy fact emerges, that the

colouring of the clinical pictures is influenced by age *in a very decided manner*. The cases running a purely manic course begin with marked preference in youth, before the twenty-fifth year. If the observations, of which there is certainly only a small number, do not deceive, it seems that with the commencement of the years of involution the tendency to manic attacks once more increases and then rapidly and to a considerable extent decreases. Cases running a purely manic course, which begin after the fifty-fifth year, are quite the exception. The frequency of cases, in the narrow sense manic-depressive, also distinctly decreases with advancing age, although with small fluctuations, an experience which it would not be difficult to bring into accord with the slighter tendency of advanced age to manic attacks. On the other

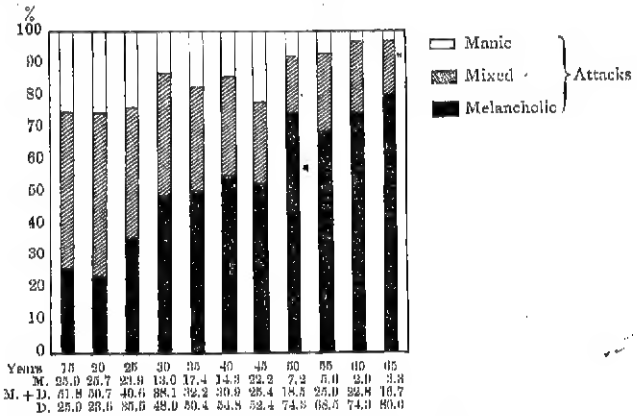


FIG. 46.—Colouring of the attacks at the different ages.

hand, depressive attacks show an *almost continuous increase* from the twentieth to the seventieth year and finally reach the height of 80 per cent. of all cases.

The fact, that states of depression are specially frequent at the more advanced ages, had already before this forced the supposition on me, that the processes of involution in the body are suited to engender mournful or anxious moodiness; it was one of the reasons which caused me to make a special clinical place for a portion of these forms under the name of melancholia. After the purely clinical foundations of this view were shaken by the investigations of Dreyfus, our representation also now lets the causal significance of age appear in a light somewhat different from my former view. It is certainly incontrovertible that after the forty-fifth year,

thus with the beginning of the climacteric in the female sex, which principally controls the numbers, a great increase of depression begins. On the other hand, consideration of the whole diagram makes it probable that it here only concerns the increase of a change in the clinical behaviour of the morbid attacks which had been coming on long before. The increase of depression is already so pronounced in the third and fourth decade and relatively progresses with such regularity, that a separation of the years of involution from the previous periods of life cannot be carried out from this point of view.

We are, therefore, forced to the conclusion that the increase of depression is not caused by the special circumstances of the years of involution, although it seems to be favoured by them, but that it in general stands in a certain relation to the *development of the psychic personality*. We have here to remember the fact, that the suicidal tendency of mankind also experiences a progessive increase in the course of life, and that children possess the ability to make good again the influence of emotional injuries in far higher degree than older people. The tendency to elaborate the incitements of life and probably also morbid disorders in the sense of depressive states, appears accordingly to increase with the maturing and the final torpidity of the psychic personality, it may be that with the gradual loss of pliant adaptability to the circumstances of life, the internal and external struggles become harder, or it may be that in the more richly developed consciousness the reverberation of mournful moods is less easily obliterated, or lastly it may be that with the greater demands of the struggle for existence the wounds which it causes become deeper.

At this point the experience which I had of the form of manic-depressive insanity among the natives of Java, is perhaps not without significance. There was a whole series of cases there which I thought I should include in this form; these were relatively not fewer than among the European patients examined at the same time. On the other hand the clinical pictures diverged in so far from our observations, that almost exclusively states of excitement, and often confusion, were concerned. Well-marked states of depression lasting for some time, such as fill the observation wards at home, I could not find at all; they are thus in any case rare. To this corresponds the absence of ideas of sin and of suicidal tendency. These observations confirm the view, that for

the form of the clinical picture, which our morbid process produces, the idiosyncrasy of the psychic personality in question is of great importance. A comparison might be made between the behaviour of the Javanese patients and that of our youthful patients, a *psychically undeveloped* population with the *immature* European youth. We might bring forward similar considerations with regard to the states in dementia præcox, and we shall later have to come back to them again in the discussion of hysterical disorders. The circumstance is also noteworthy, that the frequency of manic-depressive insanity appears to be different in different races. Reiss specially emphasizes the occurrence of numerous states of depression among the Suabians.

The distribution of a considerable number of single cases of manic-depressive insanity in regard to age will also give us information about the part which age plays in the form of the malady. I give here the percentage distribution of 1704 attacks in periods of five years. Unfortunately many cases with very numerous attacks could not here be taken into account, because the time of their appearance could not be accurately ascertained:—

Years . .	—10	—15	—20	—25	—30	—35
Per cent. .	0.2	1.4	11.2	12.3	15.2	12.5
Years . .	—40	—45	—50	—55	—60	—65
Per cent. .	11.6	8.0	9.1	7.3	5.0	3.8
Years . .	—70	—75	—80	—85		
Per cent. .	1.8	0.3	0.1	0.2		

Here it is seen that the greatest frequency of the attacks naturally falls later than that of the first attacks, about a decade. It can further be seen that between the forty-fifth and the fiftieth year also an increase of cases takes place. As it is relatively greater than the increase recorded above of the first attacks, we may conclude that the return of the attacks in the time mentioned is also facilitated; otherwise the difference on account of the considerably increased number of observations would rather have been obliterated.

The following summary gives particulars about the distribution of single attacks according to their colouring in the different decades:—

Years . . .	—20	—30	—40	—50	—60	over 60
Manic . . .	38.4	32.3	33.2	30.6	18.2	15.9
Manic-depressive	20.1	19.8	14.4	13.1	17.2	15.9
Depressive . .	41.1	47.9	52.4	56.3	64.6	68.2

The contrast in the behaviour of manic and depressive attacks is very distinct. The greatest decrease of manic attacks and the greatest increase of depressive attacks takes place between the fifieth and the sixtieth year, somewhat later than in the first attacks; the depressions, which appear in great number between the forty-fifth and fiftieth year, have thus the tendency to be repeated in the same form. In general, attacks composed of a sequence or a mixture of manic and depressive phenomena decrease likewise with age, yet they appear after the fiftieth year partly to take the place of the manic attacks, which decrease in disproportionately great measure. Unfortunately combined and mixed attacks were not kept separate from each other; I suppose that the former

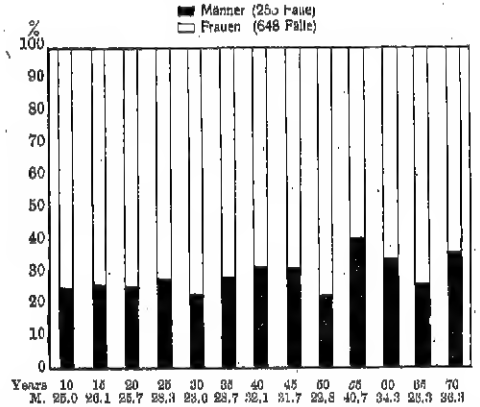


FIG. 47.—Share of the sexes in manic-depressive insanity (first attacks) at the various ages.

predominate in youth, the latter in age. In any case it can be said with certainty that in manic-depressive insanity depressive attacks are progressively substituted for manic attacks which at first are almost equally frequent.

The form of the clinical states *in detail* appears also to be influenced by age, a question about which more minute investigations are necessary. While of the depressed cases, with simple delusion of sin and indefinite ideas of persecution, 37.6 per cent. had not yet passed the thirtieth year at the commencement of the disease, only 35.3 per cent. of those with well-marked, and often extraordinary delusions remained under that age. Delusion seems thus to be somewhat more active in the later years of life, as we saw in dementia præcox. In the forms running a circular course also, very elaborate delusions certainly come under observa-

tion even in youth. The cases with states of profound anxiety belong with great preference to the later years; only 12.7 per cent. of any cases were under the thirtieth year. This circumstance also formerly strengthened me in the opinion, that a special place must be made for "climacteric melancholia."

Of the manic forms the slighter appear to begin at an earlier age; 66 per cent. of that kind of case began before

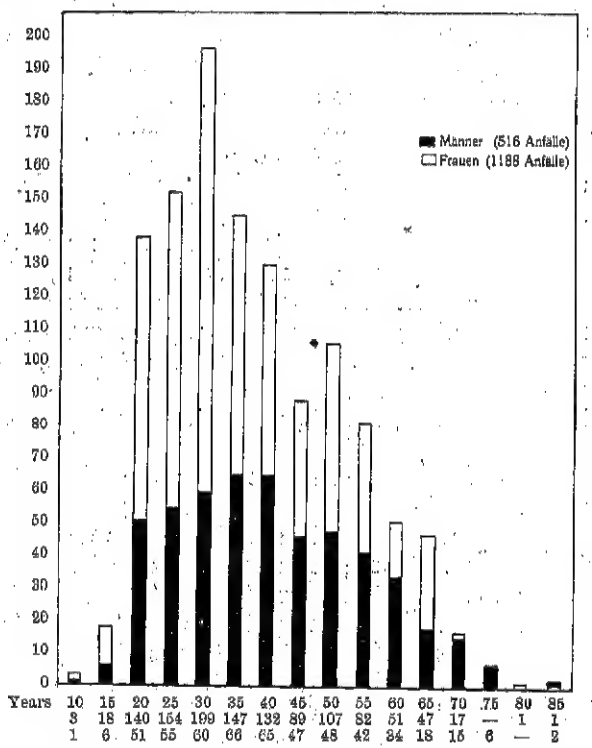


FIG. 48.—Distribution of 1704 attacks of manic-depressive insanity at the various ages.

the thirtieth year, against 58.4 of the states of severe excitement. Further we find in youth specially the cases with more severe clouding of consciousness, confusion, and states of stupor; 67.6 per cent. of these began before the thirtieth year. It would not be inconceivable, that here the tendency of youth to hysterical disorders, in especial to dazed states, influences the clinical picture. The cases with compulsive ideas had all begun before the thirtieth year; a specially

severe and peculiar morbid predisposition might be the foundation of these.

Sex.—The share of the two sexes in manic-depressive insanity is very varied. Among ourselves about 70 per cent. of the patients belong to the female sex with its greater emotional excitability. Peixoto reports what is worthy of note, that in Brazil there are among the men 6.2 per cent. manic-depressive patients, among the women 6.8 per cent. In general the women fall ill somewhat earlier; of them 49.7 per cent. were at the commencement of the malady under thirty years of age, of the men only 45.5 per cent. The share of the two sexes in the cases at the various ages is shown in Fig. 47. The share of the women is greatest in youth up to the years of development, and in the time between the twenty-fifth and thirtieth year and lastly in the climacteric. The processes connected with sexual life, the beginning of the menses, which not infrequently starts the first attack, parturition and puerperium, and also involution, without doubt here play a part. In more advanced age the share of the male sex is greater; injuries caused by life, among which arteriosclerosis appears to have a certain significance, may be causal factors. But the decrease in frequency of cases among women in more advanced age is probably more important for the displacement of the ratio.

In order to have a clearer view I have illustrated in Fig. 48 the distribution of 516 attacks among men and 1188 attacks among women in periods of five years according to the original figures. The greatest frequency of the attacks among women is seen between the twenty-fifth and thirtieth years; among men, where the fluctuations are much less, it falls somewhat later. Very noteworthy is the decrease of attacks among women before, and the increase after the forty-fifth year; the explanation might be found in the cessation of the work of reproduction on the one hand, in the commencement of the involutionary processes on the other. A considerable part of the general fall in frequency of attack is, of course, due to the death-rate. The fact appears all the more striking that also in the male sex after the forty-fifth year not only a retarded decrease, but even a slight increase of the cases becomes perceptible, a sign that here also a certain unfavourable influence of the involutionary age is present. The later diminution of the attacks takes place relatively more slowly than among the women, although their longevity should give them a preponderance.

The share of the sexes in the principal clinical forms is shown in the following summary:—

Years	—20	—30	—40	—50	—60	—70
A.—States of Depression.						
First attack, Men	46.7	53.5	58.3	69.4	73.6	77.8
Attacks in general, Men	39.7	48.7	43.5	56.8	55.3	51.2
First attack, Women	20.0	39.7	54.7	62.9	72.7	81.0
Attacks in general, Women	41.6	47.6	56.6	57.6	69.9	78.8
B.—Combined and Mixed States.						
First attack, Men	26.6	12.7	16.7	8.4	20.5	21.1
Attacks in general, Men	24.1	14.8	16.0	7.4	18.4	14.7
First attack, Women	51.5	42.2	33.6	23.7	23.7	19.0
Attacks in general, Women	18.6	21.5	13.7	14.3	16.6	16.6
C.—Manic States.						
First attack, Men	26.7	33.8	25.0	22.2	5.9	1.1
Attacks in general, Men	36.2	36.5	40.5	35.8	26.3	34.1
First attack, Women	28.5	18.0	12.7	13.4	3.6	—
Attacks in general, Women	39.8	30.9	29.7	28.1	13.5	4.6

If we now consider only the first attacks, we see that among women states of depression in youth are relatively considerably rarer than among men; in their place combined forms appear more than any other, which, apart from the most advanced ages, remain permanently far more frequent than among men. The difference in the frequency of first attacks of depression certainly disappears more and more, especially after the fiftieth year; the same is true for the combined forms. Manic first attacks are, except in early youth, much rarer among women. In the male sex the frequency of states of depression increases continuously with age, to a considerable extent before the fiftieth year, with simultaneous decrease of the combined forms. Manic first attacks after an increase at the beginning, become progressively rarer and in more advanced age disappear almost

entirely; they are associated more and more with phenomena of depression.

The total number of attacks shows a frequently divergent picture. The increase of depressive states with age is here substantially less and more irregular, a sign that these have less tendency to frequent repetition than the manic and combined forms. On the other hand the decrease of the frequently returning manic attacks is much less, especially among the men. They come more into the foreground here because of their great tendency to relapse, among women chiefly at the expense of the combined forms, among men of the depressive forms. In consequence of this the difference between the sexes in the frequency of the depressive, as well as of the combined attacks is almost completely obliterated; the share of the manic attacks among the women remains, however, permanently smaller after the twentieth year. The circumstance is noteworthy, that the share of states of depression in all the attacks taken together among men is permanently smaller, among women on the other hand at first greater than in the first attacks. That signifies that these states exhibit among men a slight tendency, but among women, at least in the first decades, a great tendency to similar recurrences. In the combined form, especially among women this tendency is obviously slight; in their stead manic attacks appear later by preference. As the general result of these considerations it can, therefore, be stated that men comparatively often have attacks of depression with slight tendency to repetition, but then also have manic attacks which often recur. Women on the other hand begin most frequently with combined attacks or mania; moreover, periodic depression often occurs among them, which only in later years gradually gives place to simple attacks.

With regard to the frequency of the individual clinical forms, the investigation gives the result that among men states of simple depression appear to be more frequent, among women on the contrary those with extraordinary delusions or with anxiety. In the male sex further purely manic attacks are more frequent, while among women we often find combined attacks, and stuporous and confused states.

The length of the intervals between individual attacks appears to be not essentially influenced by the sex of the patient. According to my classification it amounted for both sexes after the first attack to 4.6 relatively 4.3 years, after the second attack to 2.8 relatively 2.0 years, after the third and subsequent attacks to 1.2 relatively 1.4 years. If any value is placed on these differences, at most it might be said that women at first usually have a recurrence sooner than men.

Personal Idiosyncrasy is, as Reiss also demonstrated lately, without doubt a coefficient for the clinical form of the disease, unless from the other point of view it must be regarded as already the expression of the existing malady. While on the average the proportion of manic, depressive, and combined forms in the patients with recognizable morbid temperament, quite corresponded to the general frequency otherwise of those forms, the behaviour was seen in detail to be according to the following summary of percentages:—

	Depressive.	Manic.	Combined forms.
Depressive Temperament .	64.2	8.3	27.5
Manic Temperament . .	35.6	23.3	41.1
Irritable Temperament .	45.5	24.4	30.1
Cyclothymic Temperament .	35.3	11.7	53.0

It is seen that from the depressive temperament preferably states of depression arise, while purely manic attacks are rare. As the latter meanwhile with the combined forms still make up a third of the cases, the moodiness arising on a depressive foundation will scarcely be able to claim a separate clinical position. From the other side we see, namely, that with the manic temperament the depressive cases only amount to a little over a third of the total. The preponderance of manic forms alone is certainly by a long way not so considerable as that of the depressive forms in the first group, but there we probably have only the expression of the general predominance of states of depression among ourselves in contrast to the behaviour of the Javanese patients mentioned above. The irritable temperament yields morbid forms almost in the average distribution, but rather more manic and rather fewer combined forms. It might accordingly be the most general as well as the most frequent, and exercise the least influence on the special form of the clinical picture. Finally, the cyclothymic temperament appears, so far as the small numbers permit of a judgment, to favour the development of combined forms, which in any case is obvious.

External Influences.—Compared to innate predisposition external influences only play a very subordinate part in the causation of manic-depressive insanity.

Alcoholism occurs among male patients in about a quarter of the cases, but is to be regarded as the consequence of debaucheries committed in excitement, not as a cause. Now and then an alcoholic colouring of the attacks is observed, which may reveal itself in very vivid auditory hallucinations, hearing long dialogues of not very flattering character, seeing illusions with reflectors, visions of animals, night terrors with heavy perspiration and trembling. Sometimes I have seen a manic attack begin with well-marked delirium tremens.

I found *syphilis* in about 8 per cent. of my male patients; it is, however, to be judged from the same point of view. Ziehen has certainly described cases of periodic or circular psychoses, which he traces back to acquired or inherited syphilis. According to my view it can only be a case there of the fairly frequent association of manic-depressive morbid phenomena with syphilis or of syphilitic psychoses with circular forms, but not with a circular insanity engendered by lues. It is noteworthy that manic-depressive patients very rarely fall ill of paralysis, while symptoms of cerebro-spinal syphilis are not altogether rare among them.

Recently it has been emphasized by Pilcz and others that manic-depressive insanity is often connected with *coarse brain disease*. Pilcz reports seven cases of apoplexy, which the malady is said sometimes to follow closely, further ten cases with tangible brain conditions. Hoppe, who twice found cysts of the pia, thinks that brain scars act to a certain degree as irritating foreign bodies and so bring the psychic disorder to development. Saiz and Taubert have described cases with brain scars. Neisser saw a circular psychosis appear after an attack of apoplexy with paralysis. I myself observed a patient in whom, after periodically returning states of depression, which immediately followed an attack of apoplexy with paralysis, a circular form developed. In spite of all isolated experiences of that kind, it must still be doubted, having regard to the enormous mass of cases developing without tangible cause, whether it here concerns more than chance coincidence. At most one might in a similar way, as holds good for a great number of other influences, regard the irritation of brain scars as the exciting cause of isolated attacks. Or one must assume that there is a special "periodic focal brain psychosis," corresponding, perhaps, to traumatic epilepsy. For this view there are, however, up till now scarcely sufficient grounds forthcoming.

The number of other causes, which are made responsible for the appearance of attacks, as well as for the origin of the whole malady, is extraordinarily large, a sure sign that no single one of them possesses really decisive significance. First, *head injuries* might be named, which, indeed, might produce brain scars in the sense just indicated. Mönkemöller, in the previous history of fifty-six cases of periodic insanity, found thirteen cases of cranial traumata. Among my own observations also there was a series of similar cases. But the head injuries had almost always occurred many years and even decades before the outbreak of the disease, and they were almost entirely absent in the female sex with its special tendency to manic-depressive insanity. As real causes of this malady they can, therefore, not be taken into consideration.

The same holds true for the *bodily illnesses* which, not rarely, precede the development of manic-depressive insanity. Typhoid, erysipelas, pneumonia, disease of the stomach and ear operations, pleurisy, cholera nostras, influenza, blood-poisoning, hæmoptysis, were specified to us as causes. Among twenty-eight cases of that kind, however, in seventeen either there had been attacks of a similar kind previously or they followed later without external occasion.

Far more frequently an attack of manic-depressive insanity follows a *confinement* closely, or it begins during *pregnancy*. Among thirty-eight cases of the former kind similar attacks appeared twenty-five times, among ten cases of the latter kind five times, also before or afterwards spontaneously. A patient suffered from mania after two confinements, but besides that frequently from manic or depressive attacks. Another woman fell ill first after confinements; this happened three times and afterwards several times spontaneously. A third became manic after a confinement and likewise after the death of a child, and depressive after giving up her business, but also had otherwise several manic and depressive attacks.

Psychic Influences.—A still greater rôle is usually ascribed to psychic influences. In especial the attacks begin not infrequently after the illness or death of near relatives. Among forty-nine observations of that kind, attacks were also observed twenty-four times without cause. A woman fell ill three times of depression after the death first of her husband, next of her dog, and then of her dove. Another patient was depressed after the death of her husband, manic

after a confinement and after a dental operation. Again, another became depressed during pregnancy, and manic after the death of her husband, but on other occasions she had attacks of various colouring. The case of another patient was similar, who became depressed after a fright and after the death of her uncle, and manic after her mother's death. Still another fell ill of mania after a confinement and after the death of a child, and of depression when she gave up her business.

That here incalculable accidents have their share is shown by the case of a patient who frequently suffered from manic and depressive attacks; she became depressed after an operation and after the suicide of her fiancé, but stood the death of her mother without falling ill. Another fell ill first after an abortion brought about by herself, and again after a confinement, but in the interval gave birth to a child without suffering from any disorder.

Among other circumstances there are occasionally mentioned quarrels with neighbours or relatives, impending or threatened law suits, fear of a misfortune, disputes with lovers, unrequited love, excitement about infidelity, financial difficulties, losses, purchases, sales, removals, fatiguing sick-nursing; engagements also and the first sexual intercourse are sometimes the occasion of an attack. Among forty-five patients, whose attacks were traced back to such causes, there were twenty-seven, who also otherwise had similar attacks. A man fell ill after an advantageous purchase of depression, but had suffered from it already previously. In another case the sale of a property, which was regarded as the cause of a depression, was successfully made null and void, but without any influence on the disease; later on there were further manic and depressive attacks.

The certain conclusion, which can be drawn from these and similar extremely frequent experiences, leads us to this, that we must regard all alleged injuries as possibly sparks for the discharge of individual attacks, but that the real cause of the malady must be sought in *permanent internal changes*, which at least very often, perhaps always, are innate. At the same time the individual case may strongly suggest the assumption of close causal relations between external occasion and attack. Thus a man fell ill of depression first after the death of his mistress, then after that of his wife. A woman twice became melancholy, each time after the death of a brother. If such attacks remain the only ones in life,

nothing appears more natural than to see in such melancholias the increase of well-founded grief going on to morbidity. That this interpretation is not appropriate, the cases prove, in which the morbid state differs completely from that of the discharging emotional shock, by the development of extraordinary delusions or by manic colouring. Further, the observations are instructive in which, in spite of the removal of the discharging cause, the attack follows its independent development. But, finally, the appearance of wholly similar attacks on wholly dissimilar occasions or quite without external occasion shows that even there where there has been external influence, it must not be regarded as a necessary presupposition for the appearance of the attack.

Certainly it happens that further independent attacks are often absent, or they are difficult to prove. Of two women, who both had depressive attacks on the death of their husbands, the one had already had an attack thirty-seven years previously; the other fell ill twenty-one years later in the same way without occasion. If, however, a survey is made of a larger series of observations, it can be easily seen that exactly the same clinical states attain to development, the one time in close association with injuries of the kind mentioned above, the other time quite independently of them, and that between these two limiting cases all imaginable transition states are demonstrable, not only in different patients, but also in one and the same case. Unfortunately the powerlessness of our efforts to cure must only too often convince us that the attacks of manic-depressive insanity may be to an astonishing degree *independent of external influences*.

Nature of the Disease.—About the nature of manic-depressive insanity we are still in complete uncertainty. Both the frequent return of the attacks and the peculiar alternation of excitement and inhibition are complete enigmas. We may first of all refer to the fact that in our nerve tissue the tendency to a periodic course of inhibitory and excitatory processes occurs in the most different domains. Meynert has searched for the explanation of the alternation of opposed states in *periodic disturbances of vasomotor innervation*. In consequence of increased irritability of the vasomotor centre, a state of reinforced tension is said to be developed in the whole arterial field with simultaneous cerebral anæmia as cause of the depressive moodiness. And exactly the deficient nourishment of the vasomotor center

caused in this way is then said further to bring about a paralysis of the centre itself, dilatation of the vessels, and hyperæmia of the brain, and the development of manic-excitement is regarded as the expression of this. It is indubitable that changes in the behaviour of the pulse correspond to the two periods of an attack; for the rest, however, the view given reckons with wholly unknown quantities. It would also be difficult to reconcile with the fact of single attacks lasting for years and even for decades, and moreover fails completely at the fact of the mixed states.

The very considerable *fluctuations of body-weight* might here also suggest more general changes in the *metabolic processes*, but our knowledge is not sufficient to provide useful points of view. Lange[1] has assumed as the foundation of periodic depressive states with psychic inhibition, which indubitably belong to the domain of the malady here described, a *gouty* mode of development, a view which, however, till now cannot be regarded as proved or even as probable. Stegmann found in "periodic neurasthenia," which certainly belongs to manic-depressive insanity, diminution of uric acid excretion at the time of the moodiness. Pardo, who has carried out comprehensive investigations into the "coprology" of the disease, is inclined to regard as its essential foundation the *intoxication* of the body by the metabolic products of *intestinal bacteria*. He observed during the attacks a change and enrichment of the intestinal flora, especially the appearance of a definite cocco-bacillus. He also thinks that the attacks are frequently started by dietetic errors and ended by diarrhœa, the two explanations would scarcely be applicable to any extent worth mentioning. The constipation beginning during the attack is said to be a protective measure of the body which by digestion destroys the injurious bacteria.

Parhon and Marbe suggest an *insufficiency of thyroid gland activity*, Muratow a special significance of the *suprarenals* for the development of the disease. Obviously in all these unproved and unprovable views there is only the reflection of the influence of current opinion. Stransky also searches for an explanation of manic-depressive insanity from the point of view of metabolic disorders. On the one hand he directs attention to the indubitable near relationship of this malady with other forms of insanity of degeneration, and emphasizes the ancestral relations between emotional life and periodicity. Further, he supports his views on the relations between Basedow's disease and manic depressive morbid phenomena and conjectures *auto-intoxication by glandular products*, which specially influence the vascular system, perhaps disorders in the metabolism of iodides. Our patients are said to be by their peculiar predisposition hypersensitive to those poisons or to be incapable of counteracting them sufficiently.

[1] Lange, Periodische Depressionszustände und ihre Pathogenesis auf dem Boden der harnsauren Diathese, deutsch von Kurella, 1896.

The remarkable changes of state often beginning so suddenly in the patients and the form of the clinical pictures recalling many intoxications (alcohol, products of fatigue), lastly, the appearance of very similar states in paralysis do, indeed, suggest the thought of *internal poisons*, but on the other side again great difficulties stand in the way of this view. The regularity, with which in many cases the alternation of states continues throughout a great part of a lifetime, the almost unlimitedly long duration of the morbid states without lasting injury to the psychic personality, the often distinct exciting influence of emotions, lastly also, what is emphasized by Stransky himself, the clinical and hereditary near relationship of the malady with other forms of insanity of degeneration would better fit an explanation of the morbid processes, which laid the chief responsibility on an *abnormal behaviour of the nerve tissue itself*. The circumstance is, perhaps, also worth mentioning that in manic-depressive insanity the special form of the picture appears to be in greater measure dependent on the psychic personality than we are accustomed to see it in pure effects of intoxication.

In connection with Morel and Doutrebente, Anglade and Jaquin have chosen the *relations between manic-depressive insanity and epilepsy* for the starting point of their consideration. They lay stress on the fact, that the neuroglia in both diseases presents an infantile appearance; from this we may conclude that there are hereditary abnormal peculiarities in it, and that it may perhaps represent a pathological anatomy of the predisposition. It concerns in both diseases *an interference with the state of equilibrium between neuroglia and nerve tissue*, of the kind that even slight causes may call forth considerable disorders, it may be in the sense of epilepsy, or in the sense of "folie." The taking together of the two diseases, which in the most different directions diverge far from each other, seems to me to be just as little a forward step, as their being traced back to a struggle

between the two tissues which are opposed to each other, as is said, " like two hostile sisters."

The opinion, which Thalbitzer has formed of the nature of manic-depressive insanity, is likewise connected with pathological anatomy. As the foundation of the malady he regards (*diseased vasomotor paths*) for the nourishment of the brain, the course of which he relegates to the triangular tract described by Helweg in the cervical spinal cord. A peculiar fineness of the fibres, which causes the tract to stand out more distinctly, is said, as developmental inhibition, to prepare the soil for the appearance of vasomotor disorders and with these of manic-depressive insanity.

CHAPTER XI.

DELIMITATION.

THE morbid form of manic-depressive insanity, as it has here been delimited and described, is composed of a great number of clinical component parts, which otherwise frequently receive a different interpretation. The starting point of the conception of the disease is formed by the doctrine of the *periodic*, or, as Magnan named them, *intermittent* psychic disorders. This doctrine was elaborated principally by the French alienists. The attention of these investigators was then directed to one of the most strking characteristics of our morbid groups, to its tendency to multiple repetition in life. At the same time it could not escape their notice that the return of the attacks takes place sometimes in the same, sometimes in changing form. This experience led next to the separation of periodic mania and melancholia ; then, as already mentioned, the compound forms were again divided according to their changing course into a series of varieties till they were collected later under the name of circular insanity, which originally was valid only for the continuous alternation of mania and depression.

Further experience, as it could not permit of the individual kinds of circular insanity being regarded as separate diseases, has also taught that the separation of the simple periodic forms from the compound cannot be carried through. As before discussed in detail, the purely manic attacks without any association with depressive symptoms, as introduction, conclusion, interpolation, or admixture, belongs to begin with to the rarities, and when we meet with one or other attack of that kind, we yet see, as in our cases 7, 8, 9, and 10, at least at another time depressive periods attain to development. But the clinical pictures of the manic attack itself resemble each other completely, whether they belong to a so-called periodic mania or to a circular form. There is no alienist, and, according to my conviction there can be none, who would be capable of recognising from the picture of the state alone, whether a given manic attack belonged to

the one or to the other group of forms. Although the manic attacks may diverge from each other ever so much, yet these differences tell us absolutely nothing about whether we have to do with a periodic mania or with a circular insanity.

The question in regard to periodic melancholy is considerably more difficult. If we are convinced that in periodic mania we have to a certain extent to do with a form of circular insanity, in which all the attacks are changed into the manic form, the idea is naturally suggested, that cases here also occur, in which the depressive attacks alone hold the field. This view gains fresh support from the fact that in association with the states of depression not only can slighter indications of manic symptoms be demonstrated with extreme frequency, as temporary exalted mood, ideas of exaltation, laughing, singing, dancing, feeling of happiness in the time of recovery, but also between the pure periodic depressions and the circular forms all conceivable transitions may be seen. Finally, attention must still be called to the mixed states for whose peculiarity and multiplicity we only gain an approximate understanding, when we regard all the opposed manic and depressive symptoms as equivalents, which can mutually replace each other and actually do appear for each other with extraordinary frequency.

In spite of all these weighty reasons, the extraordinary frequency of the cases, which run their course in several or many periods of purely depressive form without a trace of manic features, stands in the way of the temptation to unite without hesitation the whole domain of periodic melancholy with circular insanity. It is in any case incomparably much greater than that of pure periodic mania. Especially in more advanced age we see numerous patients of that kind with a few depressive attacks repeated in similar form, somewhat like our third case. But there is also the fact, that the clinical form of depression in general is far less characteristic of a definite disease than the manic type. While here in the essential point only the delimitation from paralytic (syphilitic) or catatonic states of excitement, perhaps also once in a way from expansive paraphrenia, comes into question, which for the most part is capable of rapid accomplishment, a state of depression may besides that be also of *psychogenic* or *arteriosclerotic origin*, and it may further represent the introduction to one of the *anxious* or *paranoid psychoses* of the involutionary years so little understood by us as yet. Although we have grounds for the assumption, that

the composition of the clinical picture in all these cases will show certain differences, it is yet up till now often scarcely possible from the psychic state alone to come to a reliable decision.

Certainly there is added in our case as an auxiliary characteristic the return of the attacks. From the outset, however, the possibility must not be disregarded, whether other forms do not also possess this peculiarity. On the one hand the cases appearing as a simple increase of a morbid, depressive predisposition might have the same tendency without on that account being related to circular insanity, on the other hand the depressive attacks of the involutionary years which do not recur often, even perhaps appearing only once. In the former case further investigation has shown that from the depressive predisposition states of depression, indeed, develop most frequently, but that along with them periodic manias also and combined attacks occur. There is thus no sufficient reason forthcoming for separating off those first forms. But for the comprehension of the last forms, observations, like our cases 16 and 17, are instructive, in which it is seen that here also in certain circumstances, after depression frequently repeated or lasting many years, manic periods may still be developed. But further, as was formerly explained, it has turned out that the predominantly depressive colouring of states in the involutionary years only signifies the last part of a general change of the morbid picture with advancing age, which has begun already long before, and does not at all permit of a fundamental separation of the depressive forms of the involuntionary years. We are, therefore, forced to the conclusion by all these considerations, that periodic melancholy also is not an independent disease, but a form of manic-depressive insanity. Its peculiarity consists only in this, that it develops, certainly with a somewhat different clinical signification, with special preference on the soil of the depressive predisposition and further in more advanced age.

As *periodicity* was regarded as a very important characteristic of disease, the periodic psychoses were from the outset placed in opposition to those which appear only once in a lifetime. The beginning was made with those cases, in which throughout a considerable time an approximately regular return of similar attacks actually took place. And just that kind of example led to the making of sub-divisions, which were characterized solely by the different relations between the attacks and the free intervals. But the minute

examination of a comprehensive series of cases very soon teaches, as already the small selection of our examples shows, that a regularity, even only approximate, of the course forms a comparatively rare exception among the recurrent cases. In an overwhelming majority of the cases we have to do rather with a wholly incalculable sequence of attacks sometimes more frequent, sometimes more rare, sometimes more uniform, sometimes alternating or combined, between which pauses are interpolated of extraordinarily fluctuating duration. The greater number of these cases must of course be excluded from the domain of the genuine periodic psychoses. It was assumed that here it concerned "relapsing" attacks of mania or melancholia or isolated attacks quite independent of one another. That, of course, held good especially for the cases with very few attacks in a lifetime or even with only a single one. Experience has certainly everywhere shown that the number of such cases on more accurate examination shrinks to a remarkable degree, and simple mania at least becomes an always rarer disease[1]; but without doubt there are cases enough in which only a single attack of mania can be demonstrated thoughout life.

It must meanwhile be emphasized that this fact, for the establishment of which a series of investigators have exerted themselves, is of very little significance for deciding the question of the relations between simple and periodic forms of mania and melancholia. What it depends on, is obviously the ascertaining whether the return of the attacks in those clinical forms represents an essential or a more secondary symptom. In the former case we shall have to place the "periodic" forms separate from the "simple" forms as a special group, in the latter case not so.

About this question it must first be remarked that no border line at all can be drawn between the strictly periodic forms and those which run an irregular course. Of special significance for this question is the fact, that a periodicity, in some degree satisfying, exists in numerous cases only for a certain part of the course, that it develops first in the course of the malady or even again disappears. This proves that here it concerns not a fundamental and inviolable peculiarity of the morbid process but a fluctuating characteristic; the

[1] von Erp Taalman Kip, Allgem. Zeitschr. f. Psychiatrie, liv. 119; Hinrichsen, ebenda, 86; Mayser, Archiv f. Psychiatrie, xxxi. 500; Parant Annales médico-psychol., 1910, 68, 395.

cases with a very regular course are not fundamentally distinct from the others. Moreover, we see a similar, more or less incomplete periodicity develop also in a series of other diseases, particularly in epilepsy, also in hysteria, and in certain forms of dementia præcox especially in their terminal states. We conclude from this also that the periodic recurrence of morbid attacks cannot be the standard characteristic of a definite morbid process.

That which decides whether a case of illness belongs to a certain disease or not, is rather the incontrovertible placing of the clinical details within the limits of the known forms. But no one will wish to deny that between the individual attacks of the strictly periodic forms and of the forms which only "relapse," whether manic or melancholic, the most perfect agreement exists. All attempts to find here any useful distinguishing characteristics have completely failed. We shall be able, therefore, to give up the boundary between strictly periodic and irregularly recurring forms and bring them all together to a unity.

But quite similar considerations hold good for the number of attacks in the individual patient. We know cases, in which many dozens of attacks in unending series have to be recorded. Then there are patients with six, eight, ten attacks in life which follow one another with fairly long pauses intervening. If it is admitted that these cases belong to periodic insanity, so neither can it be denied of the cases, where perhaps every fifteen or twenty years from the period of development an attack breaks out, thus altogether three or four during life. But who will assert that here the limit of "periodic" insanity is finally reached? There are, as we have seen, cases in which twenty, thirty, indeed, more than forty years pass between the attacks; naturally here the number of possible attacks in general is restricted at most to two or three, especially when the malady begins first in more advanced years.

As can be seen, it might be admitted that even the cases with only one attack belong to a strictly "periodic insanity" by the assumption of very long pauses. Since, however, in the form here discussed we are not at all concerned with an actual periodicity. but only with a tendency, sometimes stronger, sometimes weaker, to the recurrence of the same disorders, we are not at all in need of such subtleties. What rather solely and alone concerns us is, as ever again must be emphasized, the *fundamental and complete agreement of the*

general clinical morbid picture. We are wholly incapable of judging by one manic or melancholic attack, whether it will remain the only one in life, or will recur several times, or even very frequently; only the further following up of the case, which assuredly under certain circumstances would have to be continued for thirty years and more, can clear up the matter for us. At most subsidiary circumstances, the existence of a depressive or manic predisposition, an attack in early childhood, the occurrence of frequent attacks in the parents or brothers and sisters, the general probability of recurrence, give special help; also the combination of manic and depressive periods could be made use of in this direction. But beyond that all evidence is lacking. Neither does the subsequent examination of attacks appearing only once or repeatedly disclose characteristics of any kind which permit of a separation. These are the reasons, which have caused me to gather into the unity of manic-depressive insanity, besides the circular attacks, not only the periodic and relapsing forms, but also the simple forms of mania and melancholia.

A difficulty stood in the way of this conception, namely, the peculiar clinical form of the depressive states of more *advanced age*. Without regard to the fact already discussed, that here in general a very conspicuous tendency to depressive attacks appeared, which must arouse the suspicion of morbid processes of a peculiar kind, very frequently also in these forms volitional inhibition which otherwise is so characteristic of depression was absent, and often also inhibition of thought. In their place anxious excitement appeared, mostly with abundant delusions. Moreover, the course was very chronic, so that frequently after a fairly long series of years still no recovery had taken place, but rather the issue in a state of mental weakness seemed to have begun. A number of patients were also indubitably demented.

Under these circumstances I had at first thought that I should separate that kind of depressive attack of the involutionary years as a special clinical form, as "melancholia"[1] in the narrower sense, from manic-depressive insanity, since here with regard to the composition of the state, of the course and issue, in a certain sense with regard also to the history of origin, essential divergencies appeared to exist. At the same time I did not conceal from myself,

[1] Hoche, Die Melancholiefrage, 1910; Volpi-Ghirardini, Rivista di freniatria sperim, xxxvi. 161.

that in a whole series of depressive states of the involutionary years the fact that they belong to manic-depressive insanity could not be doubted both on account of their clinical form and also an account of their earlier or later association with manic phenomena. I therefore strove to find some useful distinguishing characteristics, certainly without any satisfactory result.

Further experience then taught, as in the discussion of the presenile psychoses has already been explained, that the arguments in favour of the separation of melancholia, were not sound. The dementias could be explained by the appearance of senile or arteriosclerotic disease; other cases after very long duration of the disease, some of them displaying manic symptoms, had yet still recovered, The frequency of depressive attacks in advanced age we have come to recognise as an expression of a general law which governs the change of colouring of the attack in the course of life. Lastly, the substitution of anxious excitement for volitional inhibition has proved to be behaviour, which we meet with in advancing age in those cases also which decades previously had fallen ill in the usual form, as our first and second examples demonstrate. Hübner has likewise had the experience, that melancholic attacks may run their course sometimes with, sometimes without inhibition. There is, therefore, no longer sufficient cause to separate from manic-depressive insanity the depressive states of more advanced age, which till now have been called melancholia.

A further, not inconsiderable addition to this morbid form was furnished by the mixed states, which so far had been classified each according to its colouring under the most different terms, as stupor of exhaustion, as acute dementia, amentia[1] and so on. Here at the first glance the principle laid down above appears to fail, that the form of the whole clinical morbid picture must be authoritative in order that it may be assigned to a disease, since the mixed states frequently fall outside the limits of the ordinary states in a very conspicuous way. The changes in the composition of the clinical phenomena observed in the transition periods between mania and melancholia served here as guide. They taught us that our customary grouping into manic and melancholic attacks does not fit the facts, but requires substantial enlargement, if it is to reproduce nature. At the same time it turned out that this enlargement ran out in

[1] Confusional or delirious insanity.

the direction not of the fitting in of fresh morbid symptoms, but only of the different combination of morbid symptoms known for long. Further, it was seen that the mixed states, even when they appeared not as interpolations but as independent attacks, behaved with regard to their course and issue quite similarly to the usual forms, and lastly, that they might in the same morbid course simply take the place of the other attacks especially after a somewhat long duration of the malady. With all these established facts the proof that the mixed states belong to manic-depressive insanity appears secure.

From still other directions morbid forms have been drawn into the territory of manic-depressive insanity. Specht and Nitsche have rightly pointed out that a number of querulants who used to be reckoned to paranoia, are in reality nothing but persons with manic predisposition. Specht has even made the attempt which certainly goes too far, to let the whole of paranoia be included in "chronic mania," delimited by himself, which in essentials is covered by the manic predisposition here described.

On the other hand, Hecker and Wilmanns have emphasized that a considerable number of the patients described as psychopaths, neurasthenics, hysterics, suffer from cyclothymic fluctuations of mood, and, therefore, likewise belong to the domain of manic-depressive insanity. That naturally holds good very specially for "periodic neurasthenia," Dreyfus then, following Wilmanns, ascribed in particular nervous dyspepsia essentially to cyclothymic moodiness. Kahn spoke of "circularisme viscéral," which is said to be characterized by alternation of diarrhœa and constipation. Finally, in agreement with Bleuler I think that I may without hesitation include in manic-depressive insanity "periodic paranoia" which runs its course in isolated attacks with favourable issue, since it is invariably accompanied by distinct fluctuations of mood, frequently also by transitory states of excitement, confusion, or stupor, and cannot be in any essential point delimited from states, which otherwise also we now and then meet in the course of indubitably manic-depressive psychoses.

It cannot be denied that by all these new acquisitions the range of manic-depressive insanity has increased to a very considerable extent. That in itself is, of course, no reason for doubting its unity, as little as perhaps the frequency and multiformity of tuberculosis or of syphilis

can arouse in us hesitation about the clinical states. For the present also I see no possibility of undertaking to make fundamental divisions anywhere in this wide domain. On the other hand the attempt may well be made to characterize still somewhat more precisely individual sub-groups as to their clinical peculiarities. In this direction Reiss has made an experiment with the forms which grow on the soil of well-marked manic-depressive predisposition, while Hecker, Hoche, Wilmanns, Römheld have described minutely the important morbid state of cyclothymia to which also probably in essentials "neurasthenic melancholia" described by Friedmann[1] must be reckoned. Dreyfus has given us a glimpse, though certainly still incomplete, into the specific character of the forms developing in more advanced age. Specht and Nitsche have set forth in detail the behaviour of the permanent manic states. Although the same morbid process lies at the foundation of all these forms, they are yet so different in clinical behaviour, in course, and in prognosis, that one might perhaps speak of a morbid group springing from a common root with gradual transitions between the individual forms, rather than of a uniform disease in the customary sense of the word.

Mugdan[2] has recently made the attempt to separate from the circular attacks the "alternating" cases as a special clinical unity. In these, which do not quite amount to a third of the cases of "manic-depressive insanity," we find only purely manic or depressive states, in the circular cases a conjunction of both. The former are said to be further distinguished from the latter by the greater frequency of hallucinations and delusions, by more infrequent attacks, and by more favourable prospects of cure. From my own experience I can confirm the fact, that cases with close association, and especially mixture, of manic and depressive phenomena are in general to be regarded as more severe; but I do not consider it possible in view of the numerous transition forms to draw any boundary at all here.

The extraordinary enlargement of our conception of the disease is subjected on the other hand also to noteworthy *limitations*. It must first be remembered that only a part of the cases formerly called "mania" and "melancholia" have been included in manic-depressive insanity. A considerable number of cases, which formerly were taken

[1] Friedmann, Monatsschr. f. Psychiatrie, xv. 301.
[2] Mugdan, Zeitschr. f. d. ges. Neurol. u. Psychiatrie, i. 242.

together under those names, have been included in dementia præcox, many also in toxic insanity and other smaller morbid groups. But also from the periodic cases certain forms have been split off. Without regard to circular paralysis, which we can delimit to-day with certainty, dipsomania must be remembered, which formerly was often reckoned to periodic melancholia, but which to-day has a place given to it in several groups. Further we are convinced that dementia præcox also presents cases with a periodic course, which according to their other behaviour must be removed from manic-depressive insanity.

The so-called *delusional* forms still make up a disputed domain. As far as I can judge at present, I do not think that the morbid conception of delusional insanity is a unity. I would without hesitation reckon it with manic-depressive insanity. There certainly occur, as I have already indicated above, states which are externally very similar, in certain diseases of the involutionary age; these run a very unfavourable course, and obviously are the expression of widespread destructive processes in the cerebral cortex. The clinical pictures, however, remind one more of catatonic morbid forms. "Manic delusion," which is defended by Thalbitzer, might likewise include component parts of different kinds, at one time perhaps chronic manic cases with well-marked delusions, but at another, cases of expansive paraphrenia, with unfavourable issue, which has already been described elsewhere.[1] Certainty about these questions can only be obtained by further investigation of this domain, especially from the anatomical side.

[1] Kraepelin, *Dementia Præcox and Paraphrenia*. Translation Edinburgh, p. 302. (Oct. 1919).

CHAPTER XII.

DIAGNOSIS.[1]

THE diagnosis of manic-depressive insanity is easy in those cases, in which a series of alternating or similar attacks has already preceded. In the meantime it must be noted that also in paralysis and in dementia præcox a similar alternation between excitement and mournful moodiness or stupor may occur just as here. In such cases the distinction must take account of the peculiar clinical symptoms of the attacks themselves, which we have already discussed in detail.

The slighter and slightest forms of manic-depressive insanity pass over quite imperceptibly into the forms of the morbid predisposition which we described before. In the cyclothymic forms the periods of groundless moodiness or unrestrained merriment may for long be considered as simple capriciousness, and brought into connection with all sorts of chance occurrences. Such patients, who perhaps never come into the hands of the alienist, are, as Hecker very properly has emphasized, frequently judged by the physicians, who are consulted, solely according to moody states, and they are considered to be hypochondriacs or neurasthenics, as in the corresponding manic periods they pass as healthy. Very frequently, however, in the period of depression which drives them to the physician, they have themselves a distinct feeling of the morbidity of the excitement, of which they are sometimes very much afraid. It is, therefore, in most cases easy to find out the alternation of states and the recurrence of the individual attacks and thus the nature of the malady in question.

Simple irresolution appearing suddenly without cause is so specific that it often without anything more furnishes the right key for the interpretation of the state. Such cases are extremely frequent, and are found everywhere in sanatoria, where they go through the most varied cures. If the cure coincides exactly with the transformation of mood,

[1] Bornstein, Zeitschr. f. d. ges. Neurol. u. Psych. v. 145; Thomsen, Allgem. Zeitschr. f. Psych. 1907, 631.

it attains a brilliant result, which now is ascribed to it, but unfortunately the same result does not appear, when the patient the next time in the beginning of the attack hopes for healing from it. Moreover, here also the people in the surroundings may at any time be surprised by a severe attack, although mostly the whole lifetime usually passes in an alternation between all sorts of wild actions and the presumed repentance for them, between feverish delight in enterprise and the apparent reaction after overwork.

It is often essentially more difficult to judge of the permanent manic or depressive states. Patients of the former kind, who frequently fall into conflict with their surroundings and with the public authorities, are mostly considered to be *swindlers*, or *rascals*, often even to be suffering from *moral insanity*. Without having regard to the fluctuations of the state, with which also once in a while a short transformation to depressive mood may be associated, the clinical picture is also helpful in leading to a more correct view, the permanently confident, self-righteous, often jovial mood, the lively emotional excitability, the aimlessness, unsteadiness, and the great busyness, the inaccessibility to admonition, regulations, and unpleasant experiences, the jocular derailments, the absence of criminal intentions. Just these states, but also hypomanic attacks, which run a very chronic course, present not infrequently the picture of *querulants*. Whether the querulant delusion, as Specht thought, is in general to be conceived as a form of manic-depressive insanity, will be discussed later. Here I would only remark that manic volitional excitement, otherwise than in the delusional querulant, is invariably conspicuous in the whole conduct of life, not only in common legal relations. Moreover, the manic querulant displays as a rule a more amused, exultant mood with an inclination to humorous tricks, in contrast to the measureless exasperation and animosity of querulant delusion. Finally in him, the manic patient, fluctuations of the state are frequently conspicuous, which under certain circumstances may cause a sudden, repentant renunciation of the struggle till then carried on passionately.

The permanent state of depression is perhaps to be regarded as less unequivocal as an expression of the manic-depressive predisposition. Where, however, distinct fluctuations in the severity of the states, exacerbations of the nature of a seizure, or even an occasional transformation

to unfounded merriment are observed, the relation cannot be doubted. Peculiar caution in judging is required with regard to compulsive ideas and obsessional fears, which only exceptionally make their appearance in well-marked attacks in manic-depressive insanity. Besides that there remains to be noticed the permanent disposition, which in depressive moodiness is gloomy and hopeless, in compulsion neuroses on the contrary stands in the closest connection with the appearance of the compulsion phenomena. The patients may in the latter, when they are diverted, especially also in conversation with the physician, be quite calm and even cheerful, while the psychic oppression, which accompanies the depressive predisposition, is usually much less, or not at all accessible to momentary external influence.

To decide whether an isolated state belongs to manic-depressive insanity or not without a survey of the whole course, is not always easy. The principal difficulties arise in general with *paralysis* and *dementia præcox*. If in the former disease cytological and serological investigation has now made certainty very great, the distinction between the states of manic-depressive insanity and of dementia præcox, simple as it is in the great majority of cases, may under certain circumstances be very difficult. The points of view, which here come into consideration, have been already explained in detail.[1] Here it will merely be added that to decide between the two diseases, the consideration of their history of origin may be of value. As manic-depressive insanity in general begins somewhat earlier, the probability in this direction will be somewhat greater in an attack before the twentieth year. Moreover, attacks in advanced age will much rather rouse the suspicion of manic-depressive insanity. A well-marked manic or cyclothymic predisposition scarcely leads to dementia præcox; also the occurrence of mania or melancholia in parents or brothers and sisters will point in this direction, though certainly by no means absolutely. The question is more difficult to decide in individuals with depressive or irritable predisposition. It appears that here we must keep separate several, externally similar forms. Softness, sensitiveness, dejection, lack of self-confidence are found to a greater extent in the previous history of manic-depressive insanity, shy, whimsical, repellent conduct in that of dementia præcox. Further, to the former correspond the easily inflammable,

[1] *Dementia Præcox and Paraphrenia*, p. 260.

sentimental, passionate natures, to the latter the incalculable, stubborn, rough, and violent natures.

The least occasion for mistaken diagnoses is given in general by manic states. Leaving aside paralytic and catatonic states of excitement, only the confusion with *cerebral syphilis* really comes under consideration, in which, although not exactly often, states are observed, which display very great similarity with manic states. The difficulties may be increased up to the impossibility of a certain decision, when not only the chance combination of mania with lues exists, but also one or other of the morbid symptoms as well, which point to the nerve tissue having a share in the syphilitic disease, loss of pupillary reflexes, difference in the reflexes, tabetic phenomena. Such cases are not altogether rare. If there are disorders of speech and writing, seizures with unconsciousness or even convulsions, one will be obliged to think of a syphilitic foundation for the whole state, and likewise when with relatively slight excitement and preserved sense, gross disorders of memory, weakness of judgment, and emotional dulness are conspicuous. If, however, it should turn out that the first-mentioned bodily symptoms have existed already for years unchanged, and, if the patient with increased distractibility is clever, quick at repartee, witty, his mood exultant, his conversation and actions in fine style and clever, the probability of mania with lues becomes greater. It becomes an almost absolute certainty, if already previously similar or depressive attacks have been present. In certain circumstances also the exhibition of anti-syphilitic treatment may clear up the situation ; a rapid and obvious result would speak for cerebral syphilis, its non-appearance certainly not against that.

The diagnosis of states of depression may, apart from the distinctions already discussed, offer difficulties specially when the possibility of *arteriosclerosis* has to be taken into consideration. It may at a time be an accompanying phenomenon of manic-depressive insanity, but at another time may even itself engender states of depression. Especially the physical symptoms of arteriosclerosis, increase of blood-pressure, tortuosity and rigidity of accessible vessels, vertigo, paralytic phenomena, aphasic disorders, will direct attention to this possibility. If already states of depression or mania have preceded, the causal significance of the vascular disease will be rejected for the psychic disorder ; in the other case, however, the decision will be very difficult. One is thrown back solely on the valuation of psychic morbid phenomena. Great disorder of memory and of retention without distinct inhibition of thought, further, scantiness and uniformity of the delusions, poverty of thought, emotional barrenness with convulsive weeping or laughing, weakness of volition and susceptibility to influence will speak for an arteriosclerotic foundation of the depression.

The attacks of manic-depressive insanity accompanied by greater clouding of consciousness and vivid hallucinations are frequently regarded as *amentia*.[1] The points of view, which appear to me to be of significance for the delimitation, have been taken into account in the discussion of amentia. Schmid [2] has followed the fortunes of a considerable number of patients who had presented the picture of acute confusion, when dementia præcox was thought of, but they had completely and permanently recovered. He comes to the conclusion which is certainly right, that just those states of confusion, even when they present all kinds of " catatonic " symptoms, represent forms of manic-depressive insanity far more often than is usually assumed. Many patients of that kind, especially when the attack runs a rapid course, call to mind *hysterical* half-conscious states ; indeed, I have the impression, that now and then in reality great hysterical admixture comes into consideration. But, however, flight of ideas, the merry exultant colouring of the mood, the great distractibility, and the fearless joy in enterprise are absent in the purely hysterical states of excitement. This excitement is connected by preference with definite occasions, and appears in the form of unlimited outbursts of feeling ; it discharges itself more in single actions with conscious aim, in contrast with the permanent, general manic pressure of activity. Moreover, hysterical excitement after short duration disappears for the time being rapidly and completely, while even the slightest forms of manic attack last far longer and only gradually return to the position of equilibrium.

Under certain circumstances it may become very difficult to distinguish an attack of manic-depressive insanity from a *psychogenic* state of depression. Several times patients have been brought to me, whose deep dejection, poverty of expression, and anxious tension tempt to the assumption

[1] Confusional or delirious insanity.
[2] Schmid, Zeitschr. f. d. ges. Neurol. u. Psych. vi. 125.

of a circular depression, while it came out afterwards, that they were cases of moodiness, which had for their cause serious delinquencies and threatened legal proceedings. As the slighter depressions of manic-depressive insanity, as far as we are able to make a survey, may wholly resemble the well-founded moodiness of health, with the essential difference that they arise without occasion, it will sometimes not be possible straightway to arrive at a correct interpretation without knowledge of the previous history in cases of the kind mentioned. At most it may be evident that the individuals in question are considerably more constrained and confused at the visits of the physician than in the interval.

But even when the occasion is known, caution in judgment is necessary, as, indeed, genuine circular states of depression also may be occasioned by emotional excitement. Here the circumstance is important that in the latter case the course of the attack is independent of the exciting cause. The patients are comparatively little affected by the further development of affairs, in especial not relieved even by a favourable turn of events; they bring forward delusions, which no longer stand in any relation whatever to the starting-point of their illness. In psychogenic depression on the contrary it is seen that every discussion of the sore point, every piece of news about the business, calls forth lively emotional storms, further, that every decision in the uncertainty, and let it be even unfavourable, generally exercises a reassuring effect. The judgment may be supported by the appearance of other psychogenic phenomena, tremors, disorders of gait, fainting attacks, convulsive laughing and weeping, which certainly may also occur in manic-depressive insanity, but which do not present such close relations to the exciting circle of ideas.

Not altogether infrequently manic patients, occasionally also inhibited patients, are considered *weakminded*, even when otherwise their malady has been correctly diagnosed. That is specially true of mania with poverty of thought, which is easily thought to be "imbecility with excitement". As already mentioned a judgment of that kind is extremely deceptive, as long as any distinct symptoms of mania or depression are still present. I knew a patient who for months only laughed quietly to herself in an idiotic way, at most now and then struck her neighbour, and who

was regarded by myself as weakminded; after her recovery, however, she appeared unusually clever, cultured, and refined. Another patient for more than a year made the impression of a wholly demented individual in consequence of his lack of understanding and complete incapacity to bring forth a word; he gradually came to himself and proved to be cheerful and lively, though certainly only moderately endowed. Still another patient was for many months almost completely mute, and lay in bed apparently without interest in his surroundings and with a rigid expression of countenance; but he obeyed orders, turned somersaults with a pleased look when desired, and exercised on command; later he recovered completely. As soon as the symptoms of a manic attack are clearly seen, such as indications of flight of ideas or susceptibility to influence, a merry mood or occasional jocular actions, the probability of a curable inhibition of thought will have to be kept in view. Further the absence of catatonic symptoms will, of course, have great weight.

CHAPTER XIII.

TREATMENT.

A TREATMENT according to cause of manic-depressive insanity with its roots deep down in the personality does not exist. Binswanger in one case in which the approach of an attack appeared to him to be announced by retention of nitrogen certainly succeeded in aborting it by lessening the supply of nitrogen, but this experience has hitherto remained isolated. That a very even tenor of life in *protected circumstances*, especially also with *avoidance of alcohol*, may have a certain prophylactic effect with individuals who are liable to attacks, may be regarded as probable considering the frequently indubitable influence of external injuries. Also in the quiet life of institutions attacks are often seen to run a comparatively mild course.

How far it is possible to suppress in its origin the individual attack which threatens, we do not yet know. Kohn has tried such experiments especially for the forms with short attacks quickly following the one after the other in which the appearance of a fresh exacerbation can be more accurately foreseen. He ordered very large doses of *bromides*. *Twelve to fifteen grams* are given daily, if possible beginning some days before the expected outbreak of the attack, whose first symptoms should be very accurately noted. It occasionally in fact succeeds in preventing the appearance of excitement. After the specially dangerous days are past, the dose of the remedy is very gradually decreased, and on the approach of the next expected attack it is again increased to the large quantity mentioned. Hitzig judging by a few cases has recommended the use of atropine injections; the results, however, appear to be meanwhile rather uncertain.

The appearance of attacks in pregnancy or the puerperium has now and then led to the attempt by the induction of *artificial abortion* to shorten the attack or to prevent its outbreak. The observations, which I was able to make with regard to this, were not encouraging. The disease

comes and runs its course as otherwise. Just as little does a normal confinement as a rule influence the morbid state favourably; on the contrary an exacerbation is sometimes seen. At most, therefore, measures for the prevention of pregnancy might be considered in the case of women liable to attacks, but these in themselves are also not altogether harmless from a psychiatric point of view. On the other hand we often enough see that quite irregularly in the same woman in the course of the work of reproduction, at one time an attack of manic-depressive insanity appears, at another time not. We, therefore, by no means possess any evidence at all of the greatness of the danger on a given occasion.

The treatment of manic excitement will be above everything to prevent external stimuli as far as possible. This indication is met by the placing of the patient in an *institution*, which may be dispensed with in very slight forms, as soon as the limitation of freedom is badly borne and the malady does not lead to serious injuries and inconveniences. As we know further that the excitement is always more increased by activity, we shall limit the pressure of occupation as far as possible and keep all restless patients *in bed*, which especially in physical weakness and bloodlessness is urgently to be recommended.

In very great excitement the *continuous bath* is to be advised instead of bed-treatment. The continuous bath may here be frankly called the specific means of treatment. Its beneficent and sedative effect is extremely surprising. All the other disagreeables so much feared, isolation, dirt, destruction, violence, can be wholly or at least almost wholly avoided by this measure. All other hypnotic and sedative remedies become almost superfluous, if the baths can be continued during the night also; otherwise recourse must now and then be had to paraldehyde, trional, veronal, luminal, or such things. In cardiac weakness small doses of caffeine or digitalis are in certain circumstances indicated. After the excitement has abated, the bath treatment can be very well combined with temporary stay in the open air. All injuries and furuncles must from the outset be treated with the greatest care, as they, especially in corpulent and very restless patients with weak hearts, may give occasion for severe infections and thus quickly bring about very serious danger.

The *nourishment* of the patients requires special attention; it frequently suffers by their restlessness. Abundant, easily

digested food should be given often, and according to the circumstances administered with great patience. In more severe cases *daily weighing* is to be recommended in order to judge accurately the condition of the body-weight and in case of necessity to begin tube-feeding in time.

The *psychic treatment* of acute mania has, of course, to take into account the irritability of the patient. Quiet friendliness, at a suitable moment more a humorous entering into his cheerful mood, cautious, patient tacking, do a great deal to facilitate intercourse, and often make the patient, who in unskilled hands is dangerous and stubborn, docile and good-natured. When quietness sets in, special consideration must be given to the avoidance of external incitements and temptations.

Not inconsiderable difficulties may arise in fixing the time for *discharge*, as the patients are often very impatient and urge to get out in every possible way. But even patients, who have become quite quiet, may in freedom, especially under the influence of alcohol, immediately become excited again and carry out extremely dangerous actions. The most certain indication for judging the condition is here also given by the *body-weight*.

In states of depression *bromides* are usually employed with occasional hypnotics, further, evening baths with cold douching. In greater anxiety *opium* is given with or without bromide. The dose is quickly increased from *ten up to thirty or forty drops of the tincture thrice daily*. I have not seen any more benefit from larger doses; in certain circumstances they appear to have an exciting effect. After quietness has set in, the dose is slowly reduced, and, if need be, again rapidly increased. Besides that there must be remembered strengthening nourishment, regulation of digestion, further, *rest in bed* with regular stay in the *open air*.

As the patients are in general mostly excited by those persons and things which concern them most nearly, by their relatives, their home, their vocational activity, it will be desirable, as a rule, to remove them from their accustomed surroundings. Patients, in whom there is any danger of *suicide*, must not in any circumstances be treated in the family or in a hospital run on the open-door system, but should be placed unconditionally in a closed hospital under constant observation by day and by night. An attendant sleeping in the same room, or worse still in a side-room, is not sufficient under any circumstances in cases at all serious.

Feeding often causes great difficulty because the patients resist vigorously on account of lack of appetite or in consequence of delusions; they do not consider themselves worthy to eat, they think that they cannot pay, they suspect poison or nauseating things in the food. *Kindly persuasion*, patient waiting for the right moment, careful choice of food, however, in most cases lead to the goal; in certain circumstances sensible patients abandon their resistance when they are convinced that otherwise tube-feeding is imminent.

Psychic treatment will have to be essentially limited to the keeping of emotional stimuli far off. Long conversations, letters, business arrangements, are, as far as possible, to be avoided. In cases connected with betrothals personal as well as written communication with the other partner must be stopped to begin with, but the final decision for the future is to be postponed to the time of recovery, if at all possible.

Visits of relatives also may have a very exciting effect, but I am convinced that their unfavourable influence is mostly overrated, in as far as it concerns intelligent people and only short interviews. Long seclusion of the patients from their own relatives, as formerly was often considered necessary, has frequently a very unfavourable effect. Specific comforting encouragement at the height of the moodiness is for the most part fairly ineffectual; later when the mood is clearing up, the benefit without doubt often appears greater than it is in reality. But still the consciousness of being able to confide in the physician, and especially to leave all the little daily decisions in his hands, is for many patients very reassuring; also the constantly repeated assurance that all self-tormenting is morbid and that there will be complete recovery, is often felt as a comfort in the thronging of doubts and fears. In slight cases hypnotic influence may be so far useful in combating unpleasant sensations, sleeplessness and dejection.

Great caution must be advised in the case of depressed patients with regard to discharge from the protection of the institution, as just in convalescence the danger of suicide is often especially great. Frequently considerable difficulties arise here by the impulsive home-sickness, which develops in the patients, and causes the relatives to carry through the discharge against all the warnings of the physician. Sudden, very considerable exacerbations, indeed suicidal attempts, are often enough the consequence. "I immediately regretted everything," declared one of these patients.

Many patients also wish to leave the institution only on that account, in order to be able to accomplish their suicidal intentions outside. In such cases they often manage to conceal their real mood with great skill from the physician and from their relatives. Only when the impatient urging disappears, and perfect insight with a calm quiet mood exists, when nourishment has returned to the former standard and sleep is undisturbed, may recovery be regarded as complete, and the time ripe for discharge. Exceptions are advisable only under specially favourable conditions.

PARANOIA

CHAPTER I.

INTRODUCTION

THE history of the conception of paranoia[1] is very closely connected with the whole development of our clincial views of psychiatry. The term, paranoia, which was used first by Kahlbaum in 1863 in a special sense, then by von Krafft-Ebing and Mendel, took the place of the older name *Verrücktheit*, which was given to a form of insanity essentially affecting *intellectual activity*. According to the older teaching of Griesinger, which in the main point assumed a single kind of psychic malady running a regular course in various stages, *Verrücktheit* was always the issue of a previous disorder of the emotional life. Each psychosis was said to begin with a melancholic stage, which might be followed by a period of manic excitement, then of *Verrücktheit*, of confusion and, lastly, of dementia when recovery did not take place at any point. At that time, therefore, one spoke exclusively of a "secondary" *Verrücktheit* as the unfortunate issue of a psychic disorder which had not attained to cure. As, moreover, confusion was also called "general *Verrücktheit*," which was conceived as an extension over the whole psychic life of the disorder

[1] Snell, Allgem. Zeitschr. f. Psychiatrie, xxii. 368; Griesinger, Archiv f. Psychiatrie, i. 148; Sander, ebenda, 387; Westphal, Allgem. Zeitschr. f. Psychiatrie, xxxiv. 252; Mercklin, Studien über primäre Verrücktheit, 1879; Neurolog. Zentralbl., 1909, 846; Amadei e Tonnini, Archivio italiano per le malattie nervose, 1884, 1, 2; Werner, Die Paranoia, 1891; Schüle, Allgem. Zeitschr. f. Psychiatrie, l. 1 u. 2; Cramer. ebenda, li. 2; Sandberg, ebenda, lii. 619; Smith, Journal of Mental Science, 1904, Okt.; Pastore, Giornale di psichiatria clinica e tecnica manicomiale, xxxv. 3; Sérieux et Capgras, Les folies raisonnantes, 1909; L'année psychologique, xvii. 251; Binet et Simon, ebenda xvi, 215; Sommer, Leydens Deutsche Klinik, 297, 1906; Alberti, Note e riviste psichiatria, 1908; Wilmanns, Zentralbl. f. Nervenheilk, 1910, 204.

originally more limited, the systematized delusion restricted to a few parts of the psychic life was contrasted with that as "partial *Verrücktheit*."

It was first the investigations of Snell, Westphal, and Sander, which in the 'sixties of last century led to a "primary" manner of development of *Verrücktheit* being generally recognized. The effect of this undeniable progress was that the newly recognized form of disease was as a primary disease of the intellect placed over against mania and melancholia, in which were seen the standard disorders of the emotional life. The emotional reactions occasionally observed in the former malady were said to arise as "secondary" phenomena by means of delusions and hallucinations, just as it was thought that the emergence of intellectual disorders in the "emotional diseases" could be derived as a result from the primary cheerful or mournful temper. It was, therefore, of the greatest significance for the diagnosis to know in the individual case, whether the disorders of emotion or those of intellect had been the first morbid phenomena.

The conception of *acute* paranoia, first briefly indicated by Westphal, became of special importance for the further development of the question of paranoia, with which later "periodic" paranoia was brought into connection.[1] By the displacement of the original conception which only took into account chronic, incurable states, the delimitation of the morbid state according to external phenomena became much facilitated. If the course and issue of the disease were no longer authoritative, the intellectual disorder, the appearance of delusions or hallucinations, remained as the only tangible characteristic of *Verrücktheit*. Thus it came about that a series of morbid pictures were now incorporated with it, which, regarded clinically, possessed nothing whatsoever in common with the original *Verrücktheit*, as, for instance, amentia,[2] alcoholic insanity, and numerous states which, without doubt, belong to dementia præcox or to manic-depressive insanity.

We learn from paralysis, from dementia præcox, and in a certain sense also, from manic-depressive insanity that a disease in itself may present acute and chronic forms. Here,

[1] Köppen, Neurolog. Zentralbl, xviii. 434; Thomsen, Archiv f. Psychiatrie, xlv. 803; lv. 3; Böge, ebenda, xliii. 299; Kleist, Zeitsch. f. d. ges. Neurol. u. Psychiatrie, v. 366.

[2] Confusional or delirious insanity.

however, the acute attacks are everywhere only parts of a course fundamentally chronic; on this account the prognosis with regard to the final state remains in principle the same for each morbid process. But just this characteristic fails in application to cases of so-called acute paranoia. The sifting of the morbid cases corresponding to this picture after a sufficiently long period of observation, shows undeniably that from year to year an always larger number of these belong to wholly different well-known diseases. In any case the greater number of cases of so-called acute paranoia display neither a peculiar cause, nor a special course and issue, nor any other clinical characteristics, which would permit of their being separated from other states. Personally I even doubt if with more detailed exanimation any remnant clinically of value remains over of the cases. But yet if one wishes to retain it, it is in any case more expedient not to give the name of paranoia to the morbid state, because by so doing essential characteristics of the forms of this disease generally recognized are obliterated, the insidious course, the unfavourable prospects of recovery, the permanent continuance of the delusions which appear.

There was a time when the number of the paranoiacs in our mental hospitals had grown to from 70 to 80 per cent. of all cases. The demonstration of a few delusions or hallucinations sufficed for clinical characterization. The starting-point was the conception that each paranoiac had essentially a delusion mentally worked up, "a system", which also was regarded as the foundation of his states of depression and excitement and also of his morbid actions. Certainly observation itself showed that in very many cases nothing really could be demonstrated of a delusional system, but that only a few meagre, disconnected or confused delusions were given utterance to. In order to explain the contradiction between hypothesis and findings, it was usual to seize upon the assumption, either that the patient did possess a delusional system but for some reason or other did not speak about it, or that a system had formerly existed in his mind, but that, however, it was already "disintegrated." In this case it concerned an "old paranoiac", who certainly might still be very young in years. Further experience has taught that both assumptions, although they might be appropriate once in a while in a single case, could not explain the absence of a systematized delusion in an enormous number of presumed paranoiacs. Rather it

became clear that here it concerned morbid states which according to their essential character, were accompanied, as a rule, not by systematized delusions, but by incoherent, contradictory, changing, meagre delusions. According to the principal point it concerned those forms which we now gather together under the name of dementia præcox. With these, perhaps, a few cases also of senile, epileptic, or syphilitic disease came into consideration.

But when now for the diagnosis of paranoia one came back to the demand for a delusion to some extent fixed and mentally worked up, it was seen that the group of such cases, still very large, did not at all appear to be clinically uniform. Above everything the fact stood out that the development of the disease was usually accompanied by more or less vivid and extended hallucinations, while in a smaller number of cases the development of the delusion permanently, or at least for many years, took place solely by means of morbid interpretation of actual events or by pseudo-memories. The attempt was made to rectify this difference by making a classification into hallucinatory paranoia and systematized or simple paranoia. Further, it was seen that many cases, and, indeed, by preference the forms with vivid hallucinations, displayed the tendency to relatively rapid transition to states of mental weakness, which made itself known in the extraordinariness of the delusions, lack of judgment, incoherence, and emotional dulness. In contrast to that, other patients were seen, especially those with purely systematized delusions, who remained unchanged sometimes for decades without essential loss of psychic ability.

These experiences of necessity suggested the assumption, that there would be a difference in the character of the morbid process corresponding to the difference in the course and issue. For this reason I decided first to separate off from the others the forms which develop very insidiously, and which do not lead to states of pronounced psychic weakness, as paranoia in the narrower sense. The remainder, which was far more comprehensive, represented the "paranoid" disease, a group in itself, still by no means uniform, but put together of very different component parts. As the greater number of these consisted of cases, which in many clinical features, as in course and issue, displayed unmistakable points of agreement with dementia præcox, I thought that I should first, till these questions

were further cleared up, incorporate them with that disease as paranoid forms. But further experience has caused me, as was formerly explained in detail,[1] to separate off a few smaller groups again from the paranoid forms of dementia præcox under the name of the paraphrenias, because of the divergent form of their terminal states.

Consideration of the causes and of the history of the development of paranoiac and paranoid diseases teaches us that in this direction there is very great multiplicity. Formerly, when morbid states were the principal guide for the delimitation of diseases, no special weight used to be laid on this circumstance. It seems to me, however, that with progressive knowledge of the true causes of insanity, the dependence of the clinical state on the conditions of its development becomes more distinct, although our insight into these circumstances as yet is still lamentably inadequate. If the attempt is made to classify according to this point of view, it appears that both among the paranoid and also among the paranoiac diseases in the sense delimited above, a certain number of cases is found which certainly, or at least with the greatest probability, must be traced back to definite external causes. Here there are on the one hand many alcoholic and syphilitic psychoses, but also and especially a series of psychogenic forms of insanity. It is, therefore, to be recommended, as has been done in our discussion, to separate out at the beginning cases of that kind and to combine them in special groups. We then have remaining for "true" paranoia, which alone occupies us at present, only those cases which are *developed from purely internal causes*.

Peculiar difficulties arise, as already indicated, in connection with the placing of *querulant delusion*. It was held for long to be the most characteristic form of paranoia. In it, for example, the following features are distinct, the systematization of the delusion, its uniformity and stability, further, the limitation of the morbid process to certain circles of ideas, the permanent preservation of the psychic personality, the non-appearance of phenomena of dementia. These peculiarities of querulant delusion have also served me as type for the delimitation of the conception of paranoia. It is, however, unmistakable that in one aspect a striking difference exists between querulant delusion and forms of

[1] Kraepelin, *Dementia Præcox and Paraphrenia*. Translation Edinburgh, Introduction (Oct. 1919).

paranoia otherwise similar in all the directions mentioned. In the former the delusion is connected *with a definite external occasion*, with a real or supposed legal wrong which stirs the emotions greatly. In this respect it rather resembles other psychogenic diseases, especially many forms of prison psychoses and traumatic neuroses. The question will, therefore, have to be examined whether the relationship of querulant delusion to the clinical forms named is closer than to the paranoiac diseases. On the ground of the experiences before me, I thought that I must answer this question in the affirmative, and on that account I have placed querulant delusion, which formerly was regarded as a sub-form of paranoia, in the group of the psychogenic psychoses, in the neighbourhood of those other morbid forms which likewise take on querulant features.

It must, however, be emphasized that this displacement has only a comparatively subordinate significance. In a certain sense a psychogenic mode of development may be ascribed also to paranoia; in it definite actual experiences may acquire a decisive influence on the formation of the delusional system. The difference lies only in this, that here the real driving powers for the morbid working up of events are solely in the patient himself, while in the various querulants the external occasion furnishes the deciding factor for the beginning of the illness. It certainly must be pointed out that in the latter case also a peculiar predisposition must form the general foundation for the development of querulant phenomena, as even with the same external conditions only a fraction of the cases take this direction. The differences in the history of origin of querulant delusion and paranoia, therefore, run out only in the direction of a certain displacement of the relations between external, psychogenic influences and internal morbid causes. But besides that there is still further the special idiosyncrasy of the querulant tuned to strife with legal authority, the development of which by external occasion is driven into a very definite direction diverging in manifold ways from the conduct of the paranoiac.

If with the help of these explanations the attempt is made to define the conception of paranoia, as it forms the foundation of the following exposition, stress would be laid on this feature of it, the *insidious development of a permanent and unshakable delusional system resulting from internal causes*, which is accompanied by *perfect preservation of clear*

and orderly thinking, willing, and acting. At the same time that deep-reaching transformation of the whole view of life that "*Verrückung*" of the standpoint in regard to the world around, is usually accomplished, which was characterized by the name "*Verrücktheit*".

The development of the morbid conception here discussed has been essentially different in French psychiatry. While in Germany it concerned principally questions of separating and grouping mental disorders, the French investigators made far more effort to describe isolated clinical forms in the most vivid way possible. The manifold content of the delusions, of the "délire", was taken into account, its origin from hallucinations or delusional interpretations, "interprétations délirantes," its elaboration (délire systématisé), the general psychic state of the patients ("folie lucide, raisonnante"). The works of Falret and Lasègue were of special significance for the question discussed here. The former described the progressive development of the delusional formation, from the preliminary period to that of systematic building up, and lastly the monotonous fixation of the delusion, and so characterized a peculiarity of the course which we often find in true paranoia, but also in dementia paranoides and in paraphrenic disease. Lasègue described the morbid picture of the persecuted persecutors, of the "persécuteurs persécutés," which includes, namely, the querulants, but also other forms of the delusion of persecution in which the patients finally proceed to dangerous attacks on their supposed enemies.

From an essentially different standpoint Magnan came nearer to the solution of the question of paranoia. His clinical views are dominated by the endeavour to separate the mental disorders of the degenerate from the forms arising on a healthy foundation. The characteristic paranoid disease of the last group is "délire chronique à évolution systématique," already discussed by us, while to the first belong the persecuted persecutors and the querulants, and also those delusional morbid forms which are more or less remote from the type of "délire chronique" by reason of their "atypical" formation, by suddenness of development, combination of delusions of different kinds, and divergencies in the course. If the ground of classification which was authoritative for Magnan can scarcely any longer at present be regarded as justified, yet his classification, which to a certain degree separated the querulants and true paranoiacs

from other paranoid diseases, signified a decided step in advance.

The latest development of French psychiatry has brought conceptions of the doctrine of paranoia, which, notwithstanding many differences in detail, yet move pretty much in the same paths as the discussion attempted here. Régis has postulated a "psychose systematisée progressive" which with its chronic development of a delusional system without hallucinations might correspond in the main to "true" paranoia. Sérieux, who has written a great deal about these questions, separates sharply from each other the "délire d'interprétation" and the "délire de révendication"; the former corresponds accurately to our paranoia, the latter to querulant delusion. That I consider this separation well-founded, and why I do so has been already explained. Finally, various investigators, especially Dupré, have described a "délire d'imagination," in which pure imaginations, relatively pseudo-memories, without connection with real perceptions, are said to be the driving power of the delusion formation. Neisser also has spoken of a "confabulating paranoia." If I disregard confabulating paraphrenia[1] already described, it seems to me that no genuine paranoiac state can be separated off from the point of view mentioned. Certainly fantastic inventions and pseudo-memories frequently play a considerable part in the history of origin of the delusion, but yet always only along with other delusional occurrences. When the former exclusively dominate the condition, it might rather concern morbid liars and swindlers, "mythomanics" according to Duprés.

[1] *Dementia Præcox and Paraphrenia*, p. 309.

CHAPTER II.

GENERAL MORBID SYMPTOMS.

THE morbid picture of paranoia is comparatively poor in detail, as the more striking disorders only extend over limited domains of the psychic life, and leave others wholly untouched or nearly so. Observation and perception in general proceed without hindrance, although the impressions are often morbidly interpreted. The patients remain permanently sensible, clear, and reasonable. Genuine hallucinations do not occur, as according to more recent experience and in agreement with Sérieux I must assume. In one of my cases, in which after the disease had lasted for many years numerous hallucinations of hearing were developed, it turned out later that syphilitic brain disease probably existed.

Visions.—On the other hand the patients not infrequently tell of isolated or fairly frequent *visionary experiences*, which are mostly referred to the night-time, but occasionally also are said to have appeared during the day on any special occasion. They see stars, shining figures, divine apparitions. It is possible that here it frequently concerns states of dreamy ecstasy. In other cases natural occurrences are misinterpreted; in the full moon God the Father becomes visible; a cloud takes on the form of an apocalyptic animal. But sometimes the descriptions given by the patients, which are mostly connected with events which took place long ago, arouse the suspicion of pseudo-memories; thus a female patient alleged that at the age of four she saw heaven opened. Sometimes on these occasions the patients also receive orders or assurances from God; the blessing of Esau was given to a patient on the left shoulder, the blessing of Jacob on the right. Others are threatened by the devil, strangled, endure conflicts. Such experiences are always regarded by the patients as supernatural events which do not belong to ordinary experience. A few patients also perhaps assert that they are in constant communication with God, that they receive inspiration from him, but there it never is a

case of real hallucinations of hearing, but always only of the emergence of exhorting, warning, assuring thoughts, which in the manner of the "voice of conscience" are traced back to supersensual influences.

Memory and Retention show no disorder in domains lying outside of the delusion. *Pseudo-memories* are, however, extremely frequent; they usually stand in the closest relation to the morbid circle of ideas. Sometimes it is only a wrong valuation and a transformation of experiences subsequent to their occurrence, sometimes it is the emergence of wholly invented utterances or events in the form of memory pictures. The patient reports communications, which have been made to him in a mysterious way, meetings, which he has had with prominent people, strange attacks, to which he was exposed. The blind implicit confidence is always very remarkable in these cases, which is given to the alleged utterances of any individuals whatsoever about the most important secrets. Often very complicated experiences are narrated with all details. The jealous man saw and heard his wife misdemean herself in the most shameless way with his rival; a shot fell on the patient which tore off his hat and stretched him on the ground; at the same time someone appeared with a knife in order to mangle his face past recognition.

Sometimes one can trace directly how such memories emerge in the patient and become fixed. Some patients allege that they already knew beforehand of the occurrence of this or that event, thus of their being brought to the asylum; it has all of a sudden occurred to them again. One patient said that everything that he had thought to himself had come true already before this; others assert that they can prophesy. The extraordinariness and undisguised improbability of the proffered narratives often makes it easy to recognize them as pseudo-memories. Here belong the statements of those, who are expecting thrones, about the information which was given to them already in their youth about their birth and about their claims.

In other cases when the patients with absolute conviction report observations which are within the limits of the possible or even of the probable, it may become extraordinarily difficult to discover the morbid history of origin of the pseudo-memories. Thus in delusions of jealousy one is often in doubt how far real occurrences or delusional inventions are the foundation of what the patients say

about the alleged suspicious observations, indeed about the apparent admissions of the husband. Apart from general grounds of probability, the latter assumption will be justified if the patients adorn their narrative with very exact details always increasing on repetition, when they only produce their alleged observations a long time after the event, and also when their conduct at the time of the events and after has not in the least corresponded with what would have been expected in reality.

In my opinion, the part played in paranoia by pseudo-memories has often been underestimated. The statement is not infrequently found that the delusions in such cases may go back to early childhood, a circumstance which has been regarded as a strong argument in favour of the origin of the malady being a morbid disposition. Although the correctness of this view may be acknowledged without reserve, I yet consider that its substantiation by the statements of the patients about delusional experiences in childhood is not sound. Obviously these are the expression of pseudo-memories just as the corresponding narrations are in dementia præcox and paraphrenia.

Delusions of Reference.—In a still far higher degree than the picture of the past, the psychic appreciation of present experiences is influenced by the delusional processes. The disorder here dominating the morbid state can, perhaps, best be characterized by the expression delusions of reference. Numerous impressions and occurrences are not accepted in their sober every-day character, but they enter into some or other relation to the patient's own fortunes and misfortunes. Above everything the doings of his fellow human beings suffer this prejudiced interpretation.

The demeanour and the glances of the passers-by, a movement of the hand, a shrug of the shoulders, have a mysterious meaning for the patients; it is sometimes painful and tormenting, sometimes elevating and beneficent. People wish in that way to insult him, blame him, make him contemptible, warn him, encourage him, impart to him some or other important information. A phrase accidentally caught up, a remark at the neighbouring table contains a hidden allusion; it is "the customary picture-language"; "They thought that I did not understand it," said a patient. The conversation of the party at table points dimly to a secret understanding; the patient "notices that there is something there, but doesn't know what it is."

The same phrases are done to death with obvious intention on quite definite occasions. Certain songs are whistled in a remarkable manner in order to point out trivial occurrences in the patient's past, to give him hints for his work. In plays, in the most recent novel, in the newspapers there are references to his doings; the clergyman in the pulpit, a stump orator makes allusions to his person which cannot be misunderstood. It suddenly comes about that he continually meets the same people, who apparently watch him, and follow him as though by chance; people stare at him, clear their throats, cough on his account, spit in front of him or avoid him. In public restaurants people edge away from him or stand up as soon as he appears, look at him with stolen glances and criticise him. Cabmen, railway guards, workmen talk about him. Everywhere attention is directed towards him; his clothes in spite of their strangeness are copied by numerous unknown people. Isolated remarks which he has let fall immediately become public catchwords. One of my patients had called yellow the colour of the intellect; the next day everyone was wearing yellow roses, as the rose is the symbol of silence in order to indicate to him that he was clever and should be silent. "Who will reckon up everything that speaks to me here!"

All these experiences are in themselves of wholly indifferent content; they appear "quite natural to every one who is not initiated," as chance accidents, but the patient perceives only too distinctly that everything is "arranged" with consummate cunning, that it is a case of "the artificial production of chances," behind which a base conspiracy, an important state affair is concealed. Certainly the whole game is extremely cleverly managed in order to deceive him or in order not to disclose great plans for the future prematurely. As often as he asks anyone to explain frankly, giving him to understand that he sees through everything, the person assumes an innocent air and invents all kinds of subterfuges; people do not steer straight to the goal but by round-about ways, while the real aims are only alluded to in veiled indications. People come to meet him with a friendly manner in order to deceive his vigilance, entangle him in peculiar conversations, misrepresent the facts to him with mental reservation; the true meaning of this he certainly understands at once.

The following passage from the diary of a patient, who believed that he was aimed at by a secret league for the furtherance of pederasty, gives perhaps an idea of the very peculiar displacement which is accomplished in the relation of the patient to the external world:—

"That a confederacy with aims, such as are evident from these lines, makes every effort that these aims should not become public and therefore tries to make propaganda in hidden or symbolic form, is enlightening. As it now cannot be certain what attitude the individual influenced by it will assume with regard to the matter, it tries by all kinds of ingenious devices running parallel, as it were, with the main effort but in themselves innocent, to confuse him, relatively to protect itself from unpleasant disclosures. Thus, *e.g.* I had at that time got into the habit, as is indeed the case with almost everyone, of using a few stereotyped phrases, among others, "Certainly!" and "Scarcely to be believed," and lo and behold! I found these two sentences and many others as well in rapid sequence as heading to an advertisement in large letters in the *Generalanzeiger*. From that I could of course only conclude that chance and my life are thus *day by day* composed of nothing but chances, so that it would finally have become the purest fantastic double life.—That, however, is scarcely to be believed!—"

Internal connections between two events following each other by chance are very frequently assumed. A patient laid before the prime minister of Baden a map, on which the regions of the world not yet occupied were marked; immediately afterwards the German colonial policy began.

Sometimes also natural occurrences acquire a special significance for the patient. The peculiar twinkling of the stars, the changes of weather, the flight of birds, the sound of bells, symbolize in some or other way events in the life of the patient or his future. They terrify him or encourage him; they contain threats or promises. Usually it concerns isolated occurrences which find the patient in a peculiarly susceptible mood. Here there are points of contact with ordinary superstition, which likewise ascribes to chance occurrences in the external world profound relations to the individual's own fate; one need only think of the motives which may cause any one to try his luck in the lottery with just this or that number.

Delusional interpretations lead occasionally to peculiar mistakes about people in which external resemblances play no part at all. An officer riding past is the sovereign or at least his adjutant who thus wishes to give the patient a sign; a lady in a carriage is a princess who is trying to come into relations with him. His persecutors, who emerge everywhere, are at once infallibly recognized again by the patient in spite of their disguises and external changes; the mysterious loved one may also in certain circumstances assume the most manifold forms.

As the common source of pseudo-memories and of delusional interpretations we may well regard the tendency to *morbid imaginings*, as it has been described by Dupré and Logre[1] as "délire d'imagination." Series of presentations appear before the mental vision of the patients, sometimes a net of secret machinations, in whose meshes they are hopelessly entangled, sometimes delightful hopes for the future, to the fulfilment of which they look forward with confidence.

Uneasy forebodings may thrust themselves also on a healthy individual with or without external occasion; he may build castles in the air, occupy himself with the picturing of alluring possibilities of good fortune, and accept with satisfaction tokens of coming bliss. But while he always remains conscious of the unreality of his play of imagination and rectifies it by deliberation, it appears to the patient as the trustworthy expression of reality. It acquires an authoritative influence on the whole of his thought and activity and instead of being driven away by reflection and experience, it convincingly transforms treasures of memory, the mental working up of events of life, and the view of the universe.

The mental disorder which dominates the morbid picture of paranoia can, therefore, be characterized in two directions. In the first place the whole system of thought bears a morbidly personal stamp. The patient is the centre of a surrounding area which in the most multifarious way occupies itself only with him and his fortunes; what happens in his neighbourhood is not indifferent or casual, but has a profound relation to himself. But further, he lacks the capability to measure the products of his powers of imagination with the scale of sober experience. For him they have that immediate certainty of belief which leaves no room at all for doubt.

Delusion Formation.—The results of these disorders is the delusion formation peculiar to paranoia which may develop in the two fundamental directions of *ideas of injury* and *of exaltation*. The delusion here usually matures very slowly, taking many years. At first it remains within the limits of suspicious conjectures, arrogant and overweening self-conceit, secret hopes; but these draw ever fresh nourishment from the prejudiced evaluation of the experiences of life, and they become more and more fixed. Occasionally under the influence of particular conditions or internal

[1] Dupré et Logre, L'Encéphale, 1911, 209.

states, it appears that the delusion progresses more by exacerbations, unless the descriptions of the patients about such occurrences are coloured by pseudo-memories. On some or other occasion scales seem to fall from their eyes, secret connections become clear to them like lightning; the present and the future are disclosed to them by inspiration. At other times the delusion formation may apparently stand still for many years; the same ideas, at most decorated by a few pseudo-memories, are produced unchanged without being enriched by fresh delusional experiences.

The delusion of the paranoiac is invariably "systematized," mentally worked up, and uniformly connected, without gross internal contradictions. The patients exert themselves to gain a picture, certainly distorted in an extremely ego-centric fashion, of their place in the mechanism of life, a kind of view of the universe. They bring their experiences into relation with each other, they search for cause and effect, for motives and connections. Obscure points and contradictions are as far as possible set aside and smoothed over by laborious thought, so that a delusional structure arises, which, however, with all the improbability and uncertainty of its foundations, does not usually contain any apparent absolute impossibilities. The patients will even listen to objections up to a certain point. They can at once refute them, it is true, by pointing out their special internal and external experiences, but yet, at least, they acknowledge the necessity of substantiating their assertions and of defending them against doubts.

It is exactly this internal working up of the delusion which leads to its *becoming a component part of the psychic personality*, to its passing into the flesh and blood of the patients. With this is connected its irrefutability. Although the patients themselves, perhaps, admit that they seldom or never can produce a really convincing proof of the correctness of their view, yet every attempt to convict them of the delusional character of their ideas rebounds as from a wall. At most they allow that the recognition of the inner connection of all the apparent chance circumstances can only be acquired from the standpoint of that personal conviction, "which just irrefutably has existed and will exist," as a patient said. "I live in the imagination that that is no imagination." The patient, therefore, feels occasionally that an uninitiated cannot follow his trains

of thought everywhere, and so fears that his persecutors might make use of this state of affairs in order to assert that he is afflicted with the delusion of persecution. Of morbid insight there is never any question. A patient, indeed, said that he now knew himself that he was mentally ill, for

"so long as a human being knows that he is still separated from the holy and living God, his creator and preserver, still through sin and guilt or his own inner evil spirit, which lives by devouring and drinking, thus knows that he is not yet one with God, in spirit and in his conscience, therefore does not yet feel justified by the Holy Ghost, it is self-evident that he must feel himself mentally ill."

That is, of course, no morbid insight, but a paranoid interpretation of a concept, behind which the assumption of a peculiarly strict and orthodox apprehension of the relation to God is distinctly recognizable. The patient then added further, "To the holy triune God all men are mentally ill."

The *fundamental unchangeableness* of the delusions is considered with a certain amount of right to be a chief characteristic of paranoia. Only very recently doubts have arisen whether a too literal acceptance of this pronouncement corresponds with experience. On the one hand "mild forms of paranoia" have been described by Friedmann[1]; in these after a few years the delusion gradually recedes again. On the other hand Gaupp has called attention to cases of "abortive paranoia," in which, under the influence of unpleasant conditions of life, less rigid delusional systems are developed, which without actual rectification may gradually be obliterated. We shall later have to examine how far it appears feasible to place these cases within the morbid conception of paranoia. It must, however, also be taken into account that the absence of susceptibility to influence of the paranoiac delusion can scarcely be present at the beginning. Rather must we assume that in the many years of preparation the delusion grows only very gradually, that the patients offer resistance to the suppositions which are thrust upon them, rejecting them at first, and then after many inward struggles they are finally overpowered. The possibility can, therefore, scarcely be contested on principle that the development of the malady does not progress through such a period of preparation with fluctuating delusions.

Mood corresponds throughout to the content of the delusions brought forward. Many patients are shy,

[1] Friedmann, Monatsschr. f. Psychiatrie u Neurol., xvii. 467.

suspicious, dejected, irritated, others self-conscious and confident. Frequently, there is in general no conspicuous colouring of mood at all recognizable, but it perhaps appears more distinctly when the delusional ideas are discussed. Great fluctuations of emotional equilibrium do not belong to the morbid picture, as I should like to emphasize in opposition to the statements of Specht. Nevertheless one may assume with Bleuler[1] and Specht that in the history of origin of paranoiac delusion emotional tension plays a considerable part, although I consider that Bleuler's tendency to regard definite "complexes emphasized by affect" as the starting-point of paranoid delusion formation, goes too far. The two opposed directions of the delusions which are often associated with each other appear, however, to point to a close relation with emotions; we have to do with, as Maier[2] has expressed it, "katathymic" delusion formations. Their content shows, although in a morbidly developed form, such a remarkable agreement with those fears, wishes, and hopes, which even in normal individuals proceed from the feeling of uncertainty and the endeavour after happiness, that one is tempted to believe in a similar foundation here. On the one side we find the fear to be despised and mocked, threatened by a systematic persecution, deceived in wedlock, on the other side the delightful conviction of being of aristocratic descent, the favourite of a highly-placed personage, inventor and benefactor of the people, the chosen of God.

Activity and **Conduct** often remain without any very definite disorder. The patients are mostly able even to earn their living permanently without being specially conspicuous in their surroundings. Certainly all kinds of peculiarities frequently appear in the conduct of their lives. A patient expressed himself as far as possible only in writing, because he had need of quiet and of communion with God; he often fasted for several days and he gave the following explanation of this:—

"Fasting and prayer do not weaken men at all, but just the opposite; they strengthen the spirit, purify the heart, and make a man free from his sinful nature."

Many patients withdraw themselves, bury themselves in books, compose comprehensive documents; others wander

[1] Bleuler, Affektivität, Suggestibilität, Paranoia, 1906; Specht, Über den pathologischen Affekt in der chronischen Paranoia, 1901; Zentralbl. f. Nervenheilk. u. Psychiatrie, 1908, 817.

[2] Maier, Zeitschr. f. d. ges. Neurol. u. Psychiatrie, xiii. 555.

about restlessly, change their situations frequently, make their appearance sometimes at one place, sometimes at another. There is little inclination for regular and continuous employment. A merchant, who had gained a small competence in America and had returned home ill, spent his money little by little till he fell into the hands of the Guardians, as he was too proud to undertake work not suited to his high valuation of himself. Now for the first time it came out that for almost twenty years he had suffered from pronounced ideas of persecution and exaltation. Often the patients, in spite of good abilities, do not accomplish anything rightly, but are always unsuccessful; they spend far more than their circumstances allow, busy themselves with the most difficult problems, without sufficient understanding and without knowledge. Nevertheless they not infrequently are capable of exercising an important influence on their surroundings, of procuring for themselves a certain amount of consideration, of convincing some people of the correctness of their delusions, and possibly also of turning them into enthusiastic adherents, as we have described more in detail in the section about induced insanity.

The patients invariably come into contact with the alienist only late, if at all, and even then for the most part only temporarily, if they have made themselves conspicuous or given offence by any action in line with their delusion. They usually possess so much self-mastery that they habitually avoid all conflict with law and authority. Besides that they are never so tormented that they would be driven to regardless deeds of violence by overpowering inward tension. It, therefore, for the most part does not go further than comparatively harmless actions, abusive language, threats, advertisements in the newspapers, complaints to the police, attempts to force an entrance to highly-placed persons, unreasonable religious practices, the exploiting of people on the ground of delusional claims. Now and then, perhaps, a suicidal attempt may occur.

Bodily Symptoms.—In the bodily domain no tangible divergence from normal exists; appetite and sleep are as a rule not disordered. Many patients bring forward all kinds of hypochondriacal complaints, they complain of nervousness, oppression in their head, digestive weakness, for which the medical treatment is readily held responsible. They then, perhaps, take refuge in all kinds of singular cures, some of them self-invented.

CHAPTER III.

CLINICAL FORMS.

THE clinical classification of paranoiac states offers peculiar difficulties because, as it has been well expressed, there are as many forms as there are individual patients. In fact here *personal peculiarity*, which is relatively little affected by the malady, exercises a far-reaching influence on the configuration of the morbid phenomena. The multiplicity of individual features will, therefore, be much greater than, say, in the grossly destructive morbid processes of paralysis or even of dementia præcox. Nevertheless, at least, certain general trends of delusion formation are repeated so invariably, that they may well serve as starting-point for a division of the material observed into some smaller subgroups. Here we shall perhaps best begin with separating the morbid states with predominating delusions of injury and those with ideas of exaltation; in both directions some other special kinds will then be distinguished.

Delusions of Persecution.—This is the most frequent form of paranoia. The patient, who already for a long time has perhaps felt himself neglected, unjustly treated, oppressed, not sufficiently valued, makes the observation, that on some or other occasion people no longer greet him in such a friendly way as formerly, that people are now more reserved towards him, and avoid him, and, in spite of many, as he says, hypocritical proofs of friendship, will have nothing more to do with him. In consequence of this his irritability and his distrust increase; he begins to notice the behaviour of the people round him, and gradually finds numerous indications that people are systematically planning to injure him in every way, to undermine his position, to make him impossible. "I read everyone's thoughts from his face and I have good hearing," declared a patient. He is watched and spied on, detectives are sent after him, whose duty it is to keep their eye on him and collect material against him. On the street he has a feeling as if he must run the gauntlet. People look at him

contemptuously, whistle and laugh behind his back, challenge him, try to irritate him. Harmless remarks are full of concealed malice; certainly people do not speak out, they say nothing definite. In the "*Fliegende Blätter*" there is offensive abuse; everywhere there is hounding and backbiting, jeering and chicanery. "It is all lies and deceit, hypocrisy; I don't trust anyone any longer; no one wishes me well," said a patient. He is treated in the most insulting way, people ape his voice, call him by nicknames, whistle to him as to a dog, throw snowballs and stones at him. It is a concerted game; all blow the same horn; "Manus manum lavat," said a patient. Now and then the delusion is also supported by pseudo-memories; the doctors had allowed she was quite right in her ideas, declared a female patient.

The kind and the range of the continual chicanery are very multifarious. The lodgers give false names, do not pay, put beer-bottles before the door, throw them on to the street in order that people may think that the patient is a drinker. Letters directed to him are opened and read, purloined; a female patient received at the instigation of her opponent a forged denial from the district court. Consignments for customers are spoiled and rendered dirty, so that complaints constantly come in. The chimney of the stove is stopped up, boots are damaged, suits and underclothing are ruined. In lawsuits hostile machinations are instigated, so that they will be lost; the lawyers are bribed; financial intrigues, swindling and fraud are going on; the tenant is being incited to pay no rent any more. Calumnies are scattered abroad about the patient as if he had brought on himself a nervous disease by debauchery, as if he were syphilitic, or addicted to pederasty. His photograph has been sent to brothels in order to represent him as an habitué there. Forged bills were made public as if he daily took a senseless amount of alcohol. By such means he is driven from his situations, he is ruined, he loses his inheritance, and, finally, people plan to seduce him to sexual outrages, to onanism, to make him go mad, or even to make away with him altogether. The physicians are bribed, give doubtful medicines; there is poison in the beer; the taste of the food is extremely suspicious and causes colic, dizziness and noises in the ears. "I know very well what that is," declared a patient. His neighbour at table fell ill, after he had by accident drunk from the glass destined for the patient.

Thus the circle of persecutors is gradually extended further and further. If the patient changes his place of residence, he has peace at first perhaps for some time, but he very soon notices that people meet him as a personage who has already been announced, and they have complete information about him and the whole of his previous life. In all sorts of indications secret threads are spun from his former to his present surroundings. People spy after him everywhere; some individuals whom, in spite of supposed disguise, false beards, dyed hair, he recognizes everywhere again, follow his every step, so that his position is often "worse than that of a man pursued by a warrant of arrest"; it is a "boycott and a vehmgericht."

In connection with observations of this kind the patient usually has extremely remarkable ideas about the originators and the extent of the persecutions directed against him. A definite person is sometimes regarded as the real driving force, a faithless lover, a former fiancée, a sister-in-law, a colleague, the mayor. Or the freemasons, the social democrats, some or other secret society is behind it all. Of course, they have at their disposal enormous means and resources, everywhere they have aiders and abettors; not only all possible private persons, but also officials, courts, police, clergymen, physicians, journalists, authors, have a share in the general conspiracy.

The following extracts from a letter written by a female patient afford a glimpse into this circle of ideas:—

"During the fourteen years that I have lived here, I have led the life of a martyr which mocks at all comparison. It concerns the embezzlement of inherited money, and on account of this all imaginable evil and cunning was exercised, that I might be passed off as insane and so on, or that I should be made so, and that the necessary means of living, credit and honour should be taken from me. This inexcusable behaviour by day and by night is carried on by the secret police and their aiders and abettors, female and male, young or old, poor or rich—all must assist; since it is for the police! The hounding was ordered in all houses and districts of the town and no regard was had for an old widow full of years. Since I came to Munich, all my letters have been kept back, opened, and delivered without a stamp. Letters about inheritance were simply suppressed, so that I never could be present at the distribution like the other heirs. Every effort is made that I may not be seen and that I should not come into contact with anyone; indeed it is horrible and incredible that such abominable occurrences can happen, carried out by certain lawyers, who have embezzled my money; of course they have also a certain police jurisdiction at hand, which facilitates for them their infernal ongoings in order that it should not come to light; besides they are rich, with which one can close the mouth of many a crime .... When I arrived in Munich I found my house in the greatest disorder, although, before I left home, I left everything punctiliously in order. The furniture was covered with a layer of

dirt and dust, the bed-clothes were thrown about anyhow, every drawer and cupboard was opened, although I had carefully locked up everything, closed the box of keys and taken it with me; in the kitchen the pretty mirror was in fragments. It went so far that I was forced to hesitate about eating anything, for after these rascally tricks people are capable of anything, whatever can be conceived horrible and mean . . ."

Along with the delusions of persecution other delusions of all kinds, which come less into the foreground, invariably appear. We frequently find *hypochondriacal* fears. The patient notices that his memory is giving way, he is afraid of softening of the brain; he complains of pains in his head and back, oppression in his chest, cramp in his stomach, spitting of blood; his health is seriously injured, his whole body is done for. Now and then *ideas of jealousy* are present. But on the other hand an *exalted self-consciousness* frequently exists. The patient is very religious, cleverer than all other people, understands everything better, gets through "literally the double" amount of work, wanted to be something really great, to be respected, honoured, to take a higher position. A female patient had the conviction that "money must be hanging somewhere." Others assert that they must demand large sums as compensation, as inheritance, from the father of their illegitimate child.

Mood is for the most part excited, irritated, and embittered. "For me the sun has not shone and will never shine," declared a patient, "life is abominable; for me it remains empty of love. Men are wicked; already in the child there is malice and guile, scorn and derision! Why do people continually speak about me and spit in front of me? People cannot look at me and will not look at me—that is how it is."

The patient, of course, tries in every way to withdraw himself from the persecutions, changes his place of residence and situation, brings actions for damages, provides himself with weapons and dogs for his protection. He addresses querulant petitions to the authorities, the ministers, to Grand Duke and Kaiser, in which he generally makes use of very violent language, speaks of "beastly government and a brigand state," demands the removal and punishment of his opponents and makes claims for compensation. Further, he tries to stigmatize the infamous game of his enemies publicly by means of the newspapers or by broadsheets and to defend himself against the concealed charges. He also, perhaps, sets about doing something conspicuous in order to direct general attention to his endangered

position, causes a street riot, throws a petition among the assembled representatives in parliament, or tries to force his way to the reigning Prince. Some patients make suicidal attempts; others publicly ask their supposed antagonists to explain, abuse them, threaten them with violence, so that the interference of the police becomes necessary. In certain circumstances, as the morbid foundation of his procedure is not always easily recognizable, measures follow next, which still further embitter the patient. "At first a fellow like that plagues a diligent and capable man for years, and if this latter, reduced to extremity and without prospect of help, takes to self-defence, then—punishment, severe punishment!" wrote a patient.

As the patients, apart from the activities mentioned proceeding from their delusions, always behave in an orderly way and do not usually commit really serious acts of violence, they do not, as a rule, lose their freedom more than temporarily. In their behaviour they are sometimes passionate, vivacious, talkative, clever, sometimes reserved, morose, repellent. They hold firmly and resolutely to their delusions, although at times they do not speak about them at all. "He wished to remain the evil conscience of his opponent," declared a patient. Only after the morbid phenomena have lasted for decades, does the internal tension perhaps yield and with it the vividness of the delusions, without, however, a rectification of the paranoiac view of life taking place.

Delusions of Jealousy[1].—This is in many respects related to the form just described. The patient is very gradually seized by the suspicion that his wife is deceiving him and he now notices all kinds of things which strengthen him always more in the idea. His wife appears to him colder; she rejects advances, she quarrels and scolds; she goes out whenever she likes to the restaurant and to the theatre, visits a relative or a neighbour extremely often even at an unusual hour and remains an excessively long time. When she returns home, she is embarrassed, makes all sorts of evasive excuses. People make allusions, speak in a mysterious way, so that his suspicions cannot but be aroused; there are "spiritual proofs." "There are many things which taken together make a complete chain of proof," declared a patient. Another, who thought that his brother was his rival in love, got pains on cohabitation,

[1] Jaspers, Zeitschr. f. d. ges. Neurol. u. Psychiatrie, i., 567.

when his brother was infected; "I can explain the whole train of thought to myself," he said.

A considerable rôle is often played here by *pseudo-memories*. The patient reports serious charges made by his wife and confessions which she has made to him. He remembers that all sorts of suspicious men came to the house, who under various pretexts asked for his wife and had nothing to say when they only found him. Occasionally afterwards it becomes clear to him that these were the very people whom he was now suspecting, that they, therefore, had obviously had relations with his wife for a long time already. A patient narrated with all detail how his wife had repeatedly shut herself up with her lover in the water-closet. He then wanted to search out the latter quickly and he threatened to force open the locked door; on this the lover then slipped out quickly making no noise, an occurrence which happened again in exactly the same way a few weeks later. Once also he saw through the sitting-room door how his brother-in-law used his wife from behind. Another patient, described by Jaspers and observed also by myself, noticed how at night a cloth was laid over his face and his wife in bed beside him accomplished cohabitation with his rival, how both whispered together and how the lover then left the house. The too exact description of what went on, in the first case the similar repetition also, lastly, the alleged purely expectant behaviour of the patients in such circumstances make the existence of pseudo-memories indubitable.

In connection with his delusional experiences the patient brings forward the most serious accusations against his wife. She has always led him by the nose, she keeps a whole lot of lovers for herself, she has intercourse indiscriminately with hawkers and lodgers. A patient asserted that his brother continually carried on incest with his mother and adultery with his wife. Another accused his wife of having intercourse with her sons; a female patient stated that her husband had let himself go with their little daughter since her earliest childhood. The patient does not acknowledge his children any longer because they are not his, they do not resemble him; he notices in them unmistakable features of his rivals. They are bastards for whom he refuses all responsibility.

Often he brings forward still other reproaches against his wife. She is rude, extravagant, wants to get rid of him,

to put him into jail or the madhouse, to kill him; her lover is helping her. A patient declared that his wife was "mentally below par, depraved in morals, and of common, base, bold, and stupid origin"; she was good for nothing either on land or water. Many patients give utterance to all kinds of ideas of persecution. They are pursued by the parish authorities, watched by secret police agents; everything is found out by spies, letters are opened, details of their life are told everywhere; the doctor is in the conspiracy with the wife. The patient mentioned above, described by Jaspers, constantly asserted after a medical examination that he had been officially declared insane, and in spite of being told over and over again and in the kindliest way that there was no foundation for his idea, he carried on for many years an embittered struggle to obtain the annulment of this supposed "declaration of insanity".

At the same time a greatly *exalted self-consciousness* frequently exists. The patient boasts of his "sense of duty and unwearied diligence," he is a respectable citizen, he only wants what is right, he helps everyone if he can, and if it is right. "I always endeavoured to raise my standpoint," declared a patient. The patient of Jaspers, who was a very skilful watchmaker and had constructed a large and very elaborate clock, spoke of the ingratitude with which the Fatherland rewards its great sons. Others again make the impression of good-natured, weak-willed personages. Understanding for the morbidity of the ideas of jealousy is entirely absent, though a patient did say to me that he had always had a feeling of terror lest his delusion might really be true. According to this it seemed that a period of doubt had preceded in the patient who was wholly without insight; he even bored holes in the door in order to obtain certainty by watching his wife.

Invariably great *irritation* at the husband or wife supposed to be guilty develops in connection with the delusions. It comes to violent reproaches and disputes. The patient abuses his wife, tries to wring a confession from her, threatens and ill-uses her. A patient carried about a revolver with him and put it under his pillow at night, because he had to shoot his wife or stab her. Another spoke of ripping up his wife's belly. He did say afterwards that that was "only a mouth expression." "That is a thing that one does not do; one says it only that the jaw may have work." Nevertheless he became later very

violent towards his wife. Even the children are abused and beaten. A female patient threatened girls in whose company she had seen her husband. Another brought a complaint against her husband of alleged incest. A male patient brought an action against his supposed rival. Another prosecuted three of his colleagues simultaneously for adultery with his wife. Generally it comes to divorce or at least to separation, and then the patients usually quiet down by degrees without, however, the delusion being rectified.

Hypochondriacal Delusions.—A hypochondriacal form is frequently described as another kind of paranoiac delusion with depressive colouring. It is certain that hypochondriacal delusions are frequently expressed by paranoiacs. Nevertheless I have not found it possible in careful sifting of my experiences to find an indubitable case of paranoia characterized only, or at least predominantly, by this kind of delusion. I think, therefore, that I should meantime abstain from the delimitation of a hypochondriacal paranoia.

Delusions of Grandeur, Inventors.—In the various clinical forms of paranoiac delusion of grandeur the principal trends of human endeavour come to expression. The delusional inventors form a first group. The patients do not feel satisfied with their ordinary vocational activity, and occupy themselves along with that with all kinds of far-reaching, high-flying plans which gradually become the real substance of their lives. The idea at one blow to become world-famous and to acquire measureless riches by inventions which cause sensations, hovers before them. Without rudimentary knowledge, with wholly inadequate resources, they set about realizing the ideas which occur to them. They sketch out drawings, build models, search for people who will give money, and they exert themselves about patents. Sometimes it concerns plans for definite practical machines or useful objects, for railway points, a boot sole with a joint, an electrical regulator of beer-pressure, a condenser for a refrigerator, a valve for hot air apparatus, a motor plough, an aluminium coffin. In certain circumstances it may even happen that a usable idea is the foundation of such inventions, but the patients wholly lack the capacity to bring it into a useful form, as they are not at all familiar either with the technical, or with the business preliminary conditions. In their unprofessional ignorance of the real circumstances they even frequently

occupy themselves with problems, which long ago have been satisfactorily solved by others.

It is just this naive ignorance which causes them very commonly to turn straightway to the most difficult, indeed to wholly insoluble tasks. Specially liked are the following, aeronautics, the utilization of the sun's heat and of natural electricity, but especially perpetual motion, a "cheap machine for the utilization of power without any supply of power." With untiring ardour in spite of all dissuasions and derision, drawings ever more extraordinary are made, with which the patient expects to come nearer to his goal. For years he works at an impracticable model, fitting in or replacing here a cog-wheel, there a weight or a stay, so that the most remarkable monsters of wood, wire, lumps of lead, gas-pipes, old bits of brass, arise, to the completion of which the patient sacrifices every free hour and every penny which he has saved.

The peculiarity common to all these inventors is the unshakable faith in their star, in their great and unique endowment, and their brilliant future. He arrived at his inventions, of which he was still planning many, by his innate talents, declared a patient. As one cannot sing without a voice, neither can one invent anything, if one has no organ for it. Another, a very poorly endowed patient, compared himself with a well-known inventor, who had the same name as his mother; he visited in devout mood the great man's grave, and developed the firm conviction that he had left him an inheritance. The importance and especially also the economical value of their own inventions are immeasurably overestimated; in the opinion of the patients it invariably mounts up to at least millions. They, therefore, are for the most part very secretive and fear that their ideas, their intellectual treasure, may be stolen from them. They consider that their task is completely accomplished when they have brought forward some idea or other and perhaps made a few clumsy drawings to illustrate it; there is no question of any real working-out of their plans with accurate entering into detail. They are always extremely satisfied with their models, innocently overlook all difficulties and mistakes, and in spite of the most obvious failures, ever again confidently declare that only a quite unimportant improvement is still necessary in order to reach the desired goal in a short time.

In other domains also this *over-estimation of self* is often

seen. The patients make great plans for marriage, worry with their proposals ladies who are unknown to them or who absolutely refuse them, and are extremely astonished that they are not accepted with open arms. A patient said, "A Rockefeller would perhaps have said to me, 'Well, my friend, all honour to you! Here you have my daughter; I am your helper.'" They raise unfounded claims to money, demand support from the state for their efforts, expect confidently to be employed in prominent posts, as they feel themselves equal to the highest demands. Pseudo-memories may also be coloured by their exalted ideas; a patient related that the minister had assured him that money was lying ready for the working out of his inventions. In their conduct the patients often display a certain dignified reserve; one patient let his hair grow long like an artist.

Naturally the actual results do not at all correspond to the high-strung hopes. First of all the efforts to make a practical use of the inventions supposed to be so brilliant, to sell them, to obtain patents, fail. Perhaps the patient has luck once and succeeds with some trifle, but the hoped-for millions do not come in. The blame for this, in his opinion, lies not only with his lack of means, which does not allow him to take the realization of his plans into his own hands, but also with the lack of sense of people who do not know how to value his importance.

But often hostile machinations are what rob him of the well-deserved fruits of his labour. He is hoaxed; price-lists of wine are sent to him in mockery of his poverty; people work against him everywhere, hinder him from getting on, steal his inventions and make use of them. A patient, to whom the idea, in his opinion quite new, had suddenly come to construct a motor plough, and who shortly afterwards found one advertised in the newspapers, at once clearly saw that his childish drawings had been stolen from him and with all haste made use of; he always, therefore, called himself the "plundered inventor." He said that by his desperate poverty he was now a "laughing-stock," plundered, deceived, perhaps in the eyes of the whole world ridiculous and despised as well. As aider and abettor in the theft he suspected a young girl who had rejected his proposals of marriage. Another patient wrote threatening letters to a government official whom he considered responsible for his not receiving a considerable sum of money from public funds which he had asked for.

As a rule, the patients lead a quiet, depressed existence but lighted up by the unconquerable hope of ultimate success. They are not permanently discouraged by any failure and they continue to work unswervingly at their plans. Since for the most part they still earn their living in some other way, they give no occasion for difficulties, unless once in a while they are driven to unusual steps by the struggle against their opponents or the attempt to procure more means for themselves.

Delusions of Grandeur, High Descent.—A further form of paranoia is dominated by the delusion of high descent, which proceeds from the wish for power and riches. The French speak of "genealogen," "interprétateurs filiaux."[1] After perhaps long years of racking their brains and dreaming, the certain conviction arises in the patient that he is not the real child of his parents, but is of much higher and more glorious descent. An affair of no importance often provides the external occasion for the origin of this delusional idea, which for him immediately attains to indubitable certainty. In a dispute his father makes use of a violent expression which he would never employ towards his own child. The patient notices that his parents whisper in the adjoining room, turn pale on his entrance, greet him with peculiar seriousness; in his presence the name of a highly-placed personage is mentioned "significantly". On the street, in the theatre, some or other aristocratic lady looks at him in an unusually friendly way. While he is contemplating the picture of a count or a prince or the bust of Napoleon, a surprising resemblance with himself suddenly occurs to him, or finally a letter falls into his hands, between the lines of which he easily reads the significant information. A patient spoke of mysterious revelations which he dared not communicate to anyone.

With peculiar satisfaction the patient recognizes that also by the people in his more immediate and more distant surroundings the superiority of his person and of his position is more or less openly acknowledged. Wherever he goes, he is treated with unmistakable respect; strangers take off their hats to him with profound politeness; the royal family try to meet him as often as possible; the band on the parade or in the theatre begins to play as soon as he appears. In the newspapers which are laid before him by the waiter, in the books which the bookseller sends

[1] Sérieux et Capgras, L'encéphale, i. 113, 1910.

to him, he finds more or less figurative allusions to his fortunes; the passers-by on the street accompany him with approving remarks full of meaning.

This delusion also is frequently accompanied by *pseudo-memories*. In especial a number of alleged experiences of childhood betray this origin. The patient remembers how as a small child he was taken out of a beautiful castle from his real parents, dragged about in the world, and finally given a home with his alleged parents. He is still able perhaps to describe the magnificent furniture and decoration of the rooms, the beautiful park, in which he spent his childhood. Many utterances and actions of his foster-parents, the cut and colour of his clothes, the treatment which he received at school, prophetic dreams, all events great and small of his life have from his earliest youth up pointed to his descent, to his future high calling. From different sides straightforward communications were made to him about his origin and his descent; agents were commissioned to offer him considerable sums of money to come to terms, but he did not accept these.

In the further course the patient then gradually attempts to make his supposed rights known. He confides in an intimate friend, applies to the authorities, writes letters to his highly-placed parents. For the most part he has the feeling that he will scarcely find full recognition, and so he endeavours to get at least the greatest possible sum that can be agreed on. He considers himself justified in making special claims for his position, sets a value on his appearance, and at the same time has usually little inclination to lower himself by regular work. Thus he finds himself obliged to procure money on the strength of the recognition of his important claims of which there is a certain prospect. As he acts with great confidence, exerts himself to suit his behaviour to his aristocratic descent and really takes steps to further the matter, he often succeeds in finding credulous people who help him in expectation of great profit later.

He certainly meets with great opposition. Aristocratic relatives try in their own interest to prevent the recognition of his claims; his life is attempted; people try in every way to render him harmless. Even the removal to a mental hospital, which then follows when the patient has become inconvenient by his always more urgent steps to make good his claims or by the exploitation of his followers, is considered by him as a specially cunning trick of his opponents,

who have already for long indicated to him that he must end in insanity. At first he submits, as he is sure that his mental soundness will soon be recognized. In all his utterances he is very reserved, evades searching questions, and conceals his delusional ideas under blameless behaviour, till a special occasion, an emotional excitement, draws them out.

Gradually it becomes clear to him that the physicians are hired for the purpose of rendering him harmless and, if possible, mentally ill, as he could not be got at in any other way. Small unpleasantnesses and annoyances, changes in arrangements, occasional remarks, show him that the opposition and intimidation are set in motion by the people in the new surroundings also. His fellow-patients are not ill at all but bribed malingerers or police spies who by their conduct and nonsensical ongoings are to "prove" him.

Or the patient recognizes that the stay in the institution only represents a necessary link in the chain of the tests which he has to go through in order ultimately to reach his high aim. Indeed, on more careful reflection it becomes clear to him that already in his past life many indications of this purgatory in the madhouse were present. Far removed, therefore, from dejection and despair he draws fresh hope of the attainment even of his last and highest aims from the exact fulfilment of all that fate had previously destined for him. This view of his not infrequently finds special confirmation in the observation which he forthwith makes that also in the institution the mysterious indications of his brilliant future do not fail. He is treated with special attention; attar of roses is poured into his bathwater; he is flattered in figurative language; newspapers and books find their way into his hands, whose contents concern him. It cannot, therefore, escape him that the physicians detain him "on higher command," and do not at all think of considering him really ill. Among his fellow-patients he discovers very highly-placed personages who have been placed in the institution under false names as companions for him.

Sometimes the patients carry on prolonged and extraordinary struggles for their liberation and recognition. Others resign themselves to their fate with dignity in the certain expectation that their time will come some day. Sérieux and Capgras have brought forward a whole series

of historical claimants to thrones, of whom many have, perhaps, been patients of the kind here described.

Delusions of Grandeur, Prophets and Saints.—The delusion of another group of paranoiacs, the prophets and saints, of the "mystics," as they are, indeed, usually called, goes out in the direction of the relations to the transcendental world. A patient described the first beginning of the malady as follows :—

"When I was abroad from 1866 to 1873, I gradually gave up all religious ideas. I was led to this by my travels in connection with my work as carpenter or draughtsman in countries and among peoples of different religions. So in this connection I thought at last that my conscience told me what a man has to do and to leave undone, and if I act accordingly, I do not need to be afraid even of death. But unfortunately in spite of that, I felt an indescribable unrest in myself day and night which always got worse. From this God by his grace at last set me free by means of a letter from my mother to Vienna in the spring of '73, so that afterwards I had rest and peace in myself, and on this account in gratitude for this I at the same time also vowed to God the Lord to live and die for his holy word. For this reason I returned to Saxony, and I caused a disturbance in Leipzig in August '73 by some placards which I was going to post up during the night, but I was hindered by the police, so that I was put in prison for some days . . . On these placards I had given expression to my faith, that I believe that God, who speaks to us in the Bible is our only Lord, which I am obliged to believe unconditionally by reason of holy baptism and the triune God, and at the same time I expressed myself in a contemptuous and insulting manner about Kaiser Wilhelm . . . Till Whitsunday '75 I worked at my calling again practically and theoretically. But my relations to my parents became at last so strained that I completely disowned them on the ground of my belief in God's word, and I even gave up the filial relation to them and spoke to them as Mr and Mrs F. . . ."

The patients frequently occupy themselves with subtle religious speculations of all kinds, theosophy, spiritism, sectarianism. Visionary or ecstatic experiences then usually acquire a decisive significance. The patient sees in the night divine manifestations, and experiences at the same time an indescribable blissfulness; he hears the voice of God, receives orders from him; he sees the devil as well. Christ appears; at the same time a voice rings out, "Feed my sheep!" Gods calls out to him, "You are the only one!" A female patient perceived St Magdalene who announced to her, "You were not born a beggar; you are chosen for something higher." "With this dream the spiritual experiences began," she declared.

Now and then similar experiences take place during the day. A patient beheld God at the moment when he prayed, "Deliver us from evil"; it went through and through him like a higher, invisible power, as if air were breathed into him, as if fire passed through his flesh and

bones, as if the soul were leaving the body. Another suddenly heard a voice from above, "You must go forth!" and after that he felt himself guided by a higher power; on another occasion when the clock struck three he felt the Trinity in his breast which announced to him, "You are the salt of the earth." He also once saw the sun rising like an egg, and noticed that a gloriole surrounded him. A female patient felt how she hovered above the ground in church. It is certainly necessary in all stories of that kind to reckon with the possibility of *pseudo-memories*. Invariably such experiences, which are usually very exactly described and referred to a definite day, remain isolated, although now and then they are repeated in a similar manner.

Generally an extremely *personal, self-confident* working-up of the experiences of life develops. The patient always sees better into the truth, "sees all connections in his head," does not require to read any newspapers in order to know what is going on in the world. When he has visitors he feels immediately whether they have the right faith; he receives signs if people are pleased with him. He makes "continuous observations," notices that his views are carried further, his conversations are made use of. If he has said anything beautiful, a beautiful man with a lilac-coloured tie meets him, otherwise an ugly man with an unpleasant colour. A patient attributed secret significance to the appearance of the dogs which he met on the street, "Black dog with a red ribbon round its neck—reactionary who decorates himself with progressive feathers; white dog with blue bow—mawkish way of acting which points to narrow-mindedness; white dog with red ribbon—sickly sweet behaviour with radical utterances."

The conviction apparently sometimes flashing out like lightning, that he is a chosen one of God, becomes now more and more fixed in the patient. He feels that he is a prophet, "Elias redivivus," Redeemer, the Son of God, the heavenly giver of the marriage feast who is to fulfil the parable of the repeated invitation to the marriage feast, to fight the great fight with Anti-Christ and to bring in the millenium. He is the only one who has known God, "knowing all, he alone only knowing," the highest judicial authority in ecclesiastical and secular things, sent out from the Father, called to redeem all mankind; he must warn the law-givers, he waits for what God purposes for him. A patient declared that the heavenly Father sent a man every

two hundred years who should make known to the Jewish people (1) their fall, (2) the true faith. Another perceived that his brothers had got up a comprehensive organisation "with authoritative head, central personage, compensating middle point," and he added, "I suffer from the megalomania that I should be this centre; that is my disease." He described the origin of this delusion in the following terms:—

"That my brothers got up the organisation, I can only with difficulty decide, for I believe that is more a matter of feeling in me. But I will try to explain how I arrive at this view. Although I cannot prove it I have in myself the firm belief, that it is actually so. A very trifling incident was the occasion. On the performance of some duty in the shop a workman let fall the expression. That is one of the A. W.'s (initials of all the three brothers). This saying of the workman confirmed in me what I had long supposed."

It becomes clear to the patient that mankind is in terrible confusion. Men do not look up to God; what astronomers and law-givers say, is untrue. The pope is antichrist; the resurrection of the dead and the last judgment are at hand. Jesus was the serpent in the wilderness, a magician, a lazy fellow, a thief, a murderer, a liar and deceiver; Paul, Peter, and James were false prophets. The Kaiser is Saturn or Satan, whose son is the serpent that tempted Eve. The reigning sovereign is well-disposed towards Satan.

Occasionally "genealogical delusions" also emerge. A patient said that his true spiritual father was Kaiser Franz Joseph; his alleged father had appeared to him before in a dream, and slid about before him on bloody knees, and had asked him for pardon, because he had not known what his son really was. Other patients have made important inventions. Now and then ideas of persecution appear; the clergy wish to oppress the patient, the Kaiser causes him the greatest torments; in the bread there might be something wrong.

Pseudo-memories frequently appear to acquire great significance here again. The patient tells how everyone was astonished at his beauty when he was born; a neighbour said, "That will yet be a Redeemer." Later some one said, "A Messiah must come." A patient at the age of four saw heaven opened. A female patient at the age of five had a dream which was fulfilled, which then occurred to her later. When her stepmother was going to punish her, she dreamed it each time beforehand, and the same thing happened when her sweetheart embezzled 15,000 marks.

Many patients ascribe to themselves the gift of prophecy.

A patient asserted that he had foretold an earthquake; another prophesied, as it was said, conflagrations, the recent wars, the cholera, the death of her sister, her removal to the hospital. She saw a woman in Italy, who was believed to be ill, standing before her house quite well and combing her hair. In consequence of this she had a great number of believers, and she asserted that there would be a religious war, after which King Otto would become Head of the Holy Roman Empire. Other confabulations are also brought forward. A patient had met the apostle Paul in the inn at his home, as an inward voice disclosed to him. Another was cheated of threepence at a card game by Judas; a third stated that this was not the first time he had been in the world.

A few patients apparently possess the power to put themselves into *ecstatic states*. A patient said that the theosophic discipline could develop in human beings organs of sense and states of higher consciousness, of which the ordinary average European knew nothing; in this way he perceived facts and phenomena in nature, which he had not noticed before. A female patient made journeys at night which she distinguished from her dreams. According to her description she was then in her astral body; she did not need to drag her ordinary body with her; she was accompanied by an angel and a female saint. On her return "her spirit oozed into her body like oil in blotting-paper"; at the same time a hollow voice announced to her the goal of her next journey (the underworld). As the patient once slept for six months on end with short daily intervals, it was probably a case of hysterical phenomena.

After a considerable period of preparation the patients set about fulfilling their supposed *mission*. They try to recruit followers by conferences, circular letters, sermons. Generally they succeed in this. Their confident behaviour, their firm convictions and knowledge of the Bible do not usually fail of effect. Besides there is also the fact, as a patient said, "In matters of faith no one can refute another"; "In matters of faith and conscience God himself can be the only judge," declared another. The neighbours next assemble out of curiosity in the patient's house, and are astonished at his alleged power of prophesying, his addresses richly garnished with verses from the Bible; they give him presents, hold prayer meetings with him and hope for special grace from him.

The "heavenly giver of the marriage feast," already mentioned above, a master shoemaker, had a small congregation of seventeen people gathered round him, who for the most part received his prophecies of the approach of the millenium after the great and decisive battle with Antichrist very literally. Statutes of nobility were found in his house and divisions into ranks and classes, as also regulations for the most varied court servants (huntsman, chamber-lackey, keeper of the wardrobe, master of ceremonies, officer in immediate attendance for private affairs) "of his Allholy Royal Majesty of the King of the eternal Jerusalem of the kingdom of God on earth, of the King over all peoples of the earth ruled by the sceptre of his Father the Creator of the world, originated by the sign servant King David." This was worked out with extreme neatness and in great detail by one of his followers. The following short extracts may give an idea of those remarkable documents :—

"The officials of the immediate surroundings of the King are :—1. the General of the throne; 2. the General Lord Chamberlain; 3. the General Comptroller of the Household; 4. the Officers in immediate attendance on the King; 5. the General Adjutant, Aide-de-Camp, and the other Adjutants; 6. the General Master of Ceremonies with the other Masters of Ceremonies; 7. the Quartermaster-sergeant of the King; 8. the Head Body Servant of the King; 9. the Huntsmen of the King, also the General Officials of the Allholy Royal Lord Chancellor . . . That the Office of an Allholy Royal Lackey 1st Class be established according to the ordinance of the King of the Allholy Royal 2nd Class of Court rank of the Officials of Magnificence of the date of 11th May 1898 at Würzburg for the official with a definitely fixed yearly salary of 16,000 florins (ten and six thousand Gulden), which is to be paid in monthly instalments of 1333 florins. Likewise an allowance for clothes of 960 florins will be allotted to the Chamber-Lackey 1st Class, which also like the yearly income is to be paid in monthly instalments at 80 florins per month . . . . The change of dress of the King takes place after each high service and that is in the morning at 4 o'clock, and 6 o'clock and at midday at a quarter past 1 o'clock in the afternoon till half past 3 o'clock, and if an excursion is fixed for the day in question the change of dress takes place 20 minutes before the hour of departure . . . The King's beer goes to the account of the restaurant of the officials of magnificence, for which purpose the beer account book lies in the Chancellor's Office of the Head Body Servant . . . In all the apartments of the Allholy Royalty wax lights will be maintained during the night to the end of the world, which will be the wax lights of the large chandelier and the wall brackets of the halls and rooms . . . If a chamber-lackey has to accompany the King during the promenade, he must walk on the left side of the King, but the chamber-lackey must observe silence, unless the King enters into conversation with him. For as always so also in such walks the King must give the actual audience to his spirit, for which the King must be undisturbed . . . The Huntsman must appear in strictly prescribed service uniform which consists of coat, breeches, service shoes, huntsman's hat, gloves, sword, spurs, and the usual service underwear. For service the high official must have his hair dressed by his hairdresser and must also be shaved every day, if there is a strong growth of hair. A beard may be allowed . . . At 6 o'clock sharp in the morning the General Adjutant and the General Master of Ceremonies with two Masters of Ceremonies receive the King in the cabinet, after which the remaining cortège in active service then must take part. The remaining cortège joins the immediate cortège from the hall of mirrors for attendance on, and further service of the King at the table. Both the Huntsmen when they come to the table must place the chair at the table for the King and place the menu card lying there in front of him, after which then the girding of the King and the serviette service must take place; in the same way also the huntsmen must serve the King with the newspapers lying on the table, that is the huntsman must ask the King if he wishes a newspaper and which newspaper . . . During the time of service in the table-hall all unsuitable approaches to ladies, which might reveal a kind of love-affair or paving the way to it, are most strictly prohibited, as it would be a gross breach of the etiquette of the Court."

Further on the subject is the "Order of the two heavenly brides," by which a knight of the realm is raised to the highest rank of the nobility with elaborate ceremonial, the four-in-hand with silver trappings which the knight must keep, the ancestral hall, which he must furnish for himself, the service dress which may not be spoiled by rough wear or perspiration, the necessity for the court officials "to take a bath often," and by means of beard-brushes to clean the moustache from soiling by tobacco. The investiture of all the officials of magnificence takes place "on the day of the elevation of the king over all the peoples of the earth"; the kingdoms of Judea, Samaria, Galilee, Idumea, and Perea will be incorporated in his seat of government. As garments of the King there are mentioned, "vestments of the service of the absolving power," highpriestly service vestments, official teachers' garments, ornaments of the government, ornaments of church festivals, ornaments of secular festivals, house-garments, which are all accurately described. The number of the court officials runs up to 157, from the first throne-bishop primate, general throne master, throne general, general treasurer, general keeper of the archives, a crowd of directors general (and others of the cabinet upholstery school, hat-making school, cuirass-tailoring school, of the private journals) to the general court marshal, general equerry, general master of ceremonies, physician to the King, barber, hairdresser, chef, general master of fisheries, throne notary, stamp officials, and so on. The naive view of future magnificence which appears in those documents, returns frequently in the formation of sects and in religious foundations. It can easily be understood that paranoiac patients of the kind here described have not infrequently become the founders of large communities.

Further steps which the patient may take, consist in

directing letters to the spiritual and secular authorities and explaining his mission to them or declaring feud. An example of this is given in the following extract :—

" The hour namely has now come when you catholic clerical brood have played out the game with your mockery of Me and My sacred writings.! Now follows namely the reckoning for your misdeeds ! *i.e.* I now challenge you yourselves along with your antichristian scoundrels on the sacred chair in Rome to come, and meet me again and my scriptures with your well-known mockery and your other base calumnies and therefore this, that according to the Revelation of St John the preparation for the settling of accounts for your misdeeds against me may be made. The preparation for this will namely be made not only by that kind of earthquake and volcanic eruptions, that there will be a general lamentation ! There would also be made the further preparation for this by that kind of disease, famine and misery that catholic christendom would already be wholly extirpated from the earth, as soon as it would even not yet be separated by the earthquakes and volcanic eruptions from you paltry catholic parsons."

Others set about writing a book discussing the most important truths ; perhaps the third Testament, said a patient. The " heavenly giver of the marriage feast " fulfilled the parable by twice sending out the invitation in the form of comprehensive missives about the approaching millenium. The archbishop received a book weighing two and a half hundredweight. As, thereupon, nothing resulted except a complaint of disturbance of religion, the patient declared that he had now fulfilled his task, that he would acquiesce and would let perdition take its course. Another patient appeared on the streets of Munich decorated with silver gauze and with a board hanging from his neck on which was the following announcement :—

" Hither and no further goes the Word of God. Do penance, for the end of Europe is near. For ten years you have still time to do penance and then in the whole of Europe there will not be a single human being left."

He also was arrested and returned quietly to his own home, as he had now done his duty. Another patient travelled over the world, crossed the ocean twelve times, felt himself impelled to go to the Jews, who keep the law. A female patient travelled with the assistance of her followers to Vienna, in order to exorcise the plague by her penance which she carried out in numerous churches. Many patients feel that they are called to reform the world, to make people happy. A Hebrew patient urged with the greatest obduracy and in ever repeated petitions to representative bodies the keeping holy of the Sabbath day, and the payment of tithes by the Jews, as also the free distribution of bread

twice daily. He also desired that the fish in the sea should be fed and ascribed accidents at sea to this sin of omission. In a petition to the association of landlords he urged the hanging up everywhere of boards with rules for health printed on them : " One must never breathe through the mouth—One must never spit on the floor, and not on the street, only into a handerchief." On the road he reminded people that they should not sit down on stones, lest they should catch cold, advised policemen not to expose themselves with their helmets too much to the hot sun, but rather to walk in the shade.

The outward behaviour of the patients is usually in general quite orderly. For the most part they follow a calling, and frequently they appear to the people in their surroundings as specially gifted intellectually. They have usually great facility in speaking, can deliver long, flowery discourses of apparent profundity although very confused, in unctuous pulpit tone. A patient, already mentioned several times, regularly published for his followers a hectographed magazine, " From the School of Light," in which he spread himself at large over the most varied religious questions, but especially over the events at the creation, the discovery of fire, the life of antediluvian people. For his birthday a special number always appeared ; I reproduce the title-page of one of them (Fig. 49). In cases of death in the " congregation " announcements of the death were published, in which the pleasures of eternal life were promised to the departed who had taken an intimate part in all that happened in the sacred cause and had made great sacrifices to God of earthly possessions. His " spiritual God-man-nature " would enjoy these pleasures till the last day and then as a noble servant of God, risen anew in the body, would be sure of the greeting " My Allhighest Royal Majesty, the King's Son." The patients always exhibit great *self-consciousness*, sometimes concealed only by affected modesty. Many even try to express their sacred mission in their external appearance ; they let their hair and beard grow long and they put on a kind of garment such as Christ is represented as wearing.

Delusions of Grandeur, Eroticism.—This has still to be mentioned as a last form of paranoiac megalomania. The patient perceives that a person of the other sex, distinguished really or presumedly by high position, is kindly disposed to him and shows him attention which

FIG. 49.—Paranoiac Title-page.

cannot be misunderstood. Sometimes it is an intercepted glance, a supposed promenade before the window, a chance meeting, which lets this hidden love become certainty to the patient. A female patient noticed that the reigning sovereign bowed with special respect to her in the theatre, and made his children greet her. Kisses were blown to a patient. Others receive information about the affair only in circuitous ways by figurative allusions in their surroundings, advertisements in the newspapers, without perhaps their ever having seen the object of their interest.

Very soon the signs of the secret understanding increase in number. Every chance occurence, clothing, meetings, reading, conversations, acquire for the patient a relation to his imagined adventure. His love is an open secret and an object of universal interest; it is talked about everywhere, certainly never outspokenly but always only in slight indications, the profound meaning of which he understands very well. *Pseudo-memories* are frequently mixed with these. Of course, this extraordinary love must meantime be kept secret; therefore, the patient receives all messages in indirect ways, always through the mediation of others, by the newspapers, and in the form of concealed remarks. In the same way he can put himself into communication with the object of his love by the occasional dropping of hints. The flight of pigeons, which represents symbolically himself and his beloved, shows him that he has been understood, that after long struggles he will at last reach his goal. Anyone with whom he comes in contact, appears to him to be the chosen one, who has disguised herself in order to conceal her affection from the world, indeed, a secret prescience enables him at such a moment of recognition to ignore the most palpable dissimilarities, even the difference of sex.

A patient who importuned a rich lady with offers of marriage after having met her twice in a casual way, saw her again later under another name; she cast glances at him. Then he met her quite changed under still another name as patient in one mental hospital, as nurse in another; fellow-patients and the clergyman spoke about his affair in hidden words. After he had received a letter to her returned with the notice of her death—written by herself, as he perceived—he enquired after her and found her now married.

This peculiar delusion may for a long time be further

elaborated in the manner described, nourished especially by means of figurative advertisements in the newspapers, without anything wrong appearing in the remaining activities of the patient, who, indeed, tries to keep his affair secret. In the further course *dreamy hallucinations* not infrequently are associated with the delusion, the feeling of a kiss in sleep and similar things. The whole colouring of the love is at the same time visionary and romantic; the real sexual instinct in the patient is often slightly developed or developed in an unwholesome way (onanism).

Finally, the patient resolves on further steps. He promenades before the window of his adored one, sends a letter to her or manages to have conveyed to her a proposal of marriage in due form. The refusals, which now follow, perhaps offend him profoundly at first, but then appear to him only as a means to put him on trial. In this view he is strengthened by the experience that the former mysterious relations continue. By means of advertisements in newspapers he is invited to a rendezvous; remarks of passers-by indicate that he should go to his loved one; he has a feeling as if he had neglected something if he does not do it. A female patient for several decades received news in the feuilleton of the newspapers from her highly-placed beloved, whom she then used to answer by letter. In this way she learned that he had dispatched a marriage contract to her, bought a house for her, and had set aside a yearly income of 30,000 francs for her.

Meantime, things take an unfavourable turn. In the case mentioned the loved one became unfaithful, as a captain's widow had bound him in the fetters of love for fifteen years. The marriage contract was suppressed; people wished to prevent the marriage. Evil reports were spread abroad. A court lady set about boxing the ears of the patient publicly and so making her impossible; the cook was incited by a jealous princess to poison her. Morphia was scattered in the beds; there was poison in the night-light; gas came up from below. Thus the loved one can become the enemy and the persecutor of the patient, or she will at least break his pride and then marry him. She sends spies everywhere after him, has his affairs secretly examined, prevents him from getting a good post. His name is wrongly written on letters, at the end the "yours most respectfully" is left out; people jostle him on the street, put out their tongue at him, spit in front of him.

The food causes him stomach trouble and indigestion, evidently in consequence of admixtures injurious to health, so that he must do his own cooking; on this account he writes threatening letters, and appeals for protection to the police.

As can already be seen from the descriptions given, the varieties of paranoia here kept apart from each other are by no means sharply delimited forms of disease. Rather do the individual forms of the delusion quite commonly combine with each other, but in an irregular way. As a rule, however, no great difficulty will be found in placing individual cases in the various groups, if the main direction of the development of the disease is taken into account. Now and then there are certainly cases whose assignment to one or other form is in some degree arbitrary. Of the individual forms of the delusion those of persecution, jealousy, and religion appear to me to be the most frequent; but it may be that these morbid states have only more especial need of psychiatric care.

CHAPTER IV.

COURSE AND ISSUE.

THE general course of the malady has been repeatedly indicated in our description. The development always takes place *very gradually*, so that, as a rule, the beginning of the morbid manifestations can scarcely approximately be fixed. One speaks therefore of a period of preparation, in which, as precursors of the actual delusion, premonitions and conjectures emerge which again disappear, are forgotten, or perhaps rectified. Many patients express themselves with great reserve about their ideas even when from their whole conduct one is forced to the conviction that their system is firmly rooted. Such a patient came to ask if his ideas were insanity or reality.

The two opposed directions of the delusional formation may be from the beginning recognizable side by side. The patient perhaps already believes that he is not treated with due affection by his parents and brothers and sisters, but he is often misunderstood; for his peculiarity there is no comprehension. Thus a quiet opposition, gradually increasing, is developed between him and his surroundings. To his family he is as a stranger, as a being from another world; his relation to them is cold, external, unnatural, even hostile. "God is my father and the Church my mother," said a patient, who through frequent fasting wished to mortify his earthly self and so come into an intimate relation with God. The patient therefore withdraws himself from his family, behaves in a brusque, repellent way towards them, seeks solitude in order to be able to commune undisturbed with his thoughts, occupies himself with unsuitable reading which he does not understand. But at the same time a profound longing stirs in him after something great and high, a secret impulse to enterprise, the silent hope for an inconceivable happiness. More and more the conviction is strengthened in him that he was born for something "special." He believes in his "destiny," in his mission which he has to fulfil.

What in the end brings the delusion to definite recognition

appears not infrequently to be something in itself quite insignificant, as in the case described above of the patient who doubted as to the reality of his delusion. There also where the delusional formation is connected with *visions* or *ecstatic states*, one may assume a sudden emergence of the delusion. In other cases the delusional enlightenment begins in the patient, as is alleged, with experiences which are without doubt characteristic *pseudo-memories*.

The further development of the delusion takes place as a rule extremely slowly. In isolated cases, as Jaspers has shown, the delusional experiences may be crowded together in a very short period of time, so that afterwards there essentially follows only the working-up of them by logical conclusions and confabulating decoration. It has been already mentioned that occasionally also *hysterical*, or at least *psychogenic*, changes of consciousness may be interpolated; they have apparently a certain relationship with cases which we find in the delusion of persecution in prisoners and in induced insanity. Mostly, however, the formation of delusions proceeds only very gradually, perhaps indeed with greater or smaller exacerbations; the old circles of thought become wider and richer; new ones are added and they influence perception, interpretation, memory, and power of imagination in their own way.

Issue.—But generally a period of the disease can be distinguished, after which the delusion is in the main closed, and is no longer extended in its fundamental features, although it may be in details. The natural issue of paranoia accordingly is probably, as a rule, a *residual delusion*. The production of fresh delusions gradually abates, sometimes sooner, sometimes later, but the delusional system once built up generally continues unchanged in the main. Small extensions are perhaps still possible, and secondary features may fall into oblivion or even experience certain transformations, especially by pseudo-memories, but the essential delusional content remains the same. In the course of time, however, the strength of the emotional emphasis of the delusion and with that the driving-power for its development usually diminishes slowly. The patient brings, it is true, his delusional ideas to the front in the old way and at the same time also perhaps shows still a certain ardour, but they do not occupy him any longer continuously to the former extent. With that they also lose more and more their influence on his actions. The patient no longer resists

the persecutions with the old energy, strives no longer passionately towards his high goal, but he yields to his fate, and tries, as well as he can, to come to terms with circumstances.

A patient sent the following document to me :—

"If I now am silent to all insults, the day will still come, when all that will come to the light of day, what a base game has been played with me. In Munich alone there are thousands who know that I am not insane, that I only must be insane in order to be deprived of my inheritance. But these stubborn gentlemen may wait for long till I take measures against my oppressors. Oh, no, I am not going to do such a thing in my old age and I am quietly waiting for the issue, whatever may come."

A patient, already mentioned above, who considered fasting, prayer, and silence necessary on religious grounds, wrote as follows :—

"As I have been deprived of my legal rights by the authorities and have been declared of unsound mind, it is absolutely justified that I should express myself in writing; right is on this account absolutely on my side. But as this cannot be well carried out in practical life, I only make use of it in the case when conscientiousness compels me to do it, which namely is justified towards those who know my sad circumstances."

Genuine *weakmindedness* does not seem to be developed even after very long duration of the disease, although often the delusional ideas and what they are founded on, are fairly indistinct and senseless. I had the opportunity of observing a female patient till beyond her ninetieth year, who had fallen ill at the age of forty-three. Except a certain senile forgetfulness no sign of psychic weakness had appeared; in carriage and behaviour also the patient displayed no disorder of any kind, while she firmly adhered to her old delusions throughout.

Only a cursory reference is required to the fact that the *development* described here of the paranoiac personality merely represents a morbidly distorted picture of the changes in general which human thought and endeavour undergo in the course of a lifetime. The exuberance of youth urging to great deeds and experiences ebbs gradually against the resistance of life, or it is guided into regulated paths by the ripening of volition which is conscious of a definite aim. Disappointments and hindrances lead to embitterment, to passionate struggles, or to resignation which takes refuge in trifling pursuits and consoling plans for the future. But gradually the elasticity disappears; thought and volition are benumbed in the narrow circle of everyday life, only now and then are they revived by the remembrance of former hopes and defeats.

CHAPTER V.

FREQUENCY AND CAUSES.

THE frequency of paranoia in my experience does not nearly amount to one per cent. of the admissions, the reason of this probably being that the majority of the patients do not require institutional treatment or only require it temporarily. In Treptow Mercklin saw one paranoiac in about two hundred admissions. In order to throw light on these facts I give a survey of the duration of the disease up to the entrance into the institution for the small number of cases in which a fairly certain judgment could be made :—

Duration in Years	3	4	5	6	7	9	10	12	14	17	21	26	41	44
Cases	.	.	6	1	1	1	1	2	3	1	1	1	1	1	1	1

It is seen from this that the half of the patients lived undisturbed for more than nine years in freedom, before they came into the hands of the alienist; not altogether infrequently over twenty years elapse up to that point, now and then over forty years. Even then the residence in the institution, as a rule, only lasted a comparatively short time, as the patients were ready and able to comply with the demands of the life of a community. Only the claimants to thrones and similar patients, who habitually trouble highly-placed individuals and the authorities in a querulant way or exploit other people, suffer a fairly long deprivation of freedom. For these reasons it is very difficult for the individual alienist to collect facts about paranoiac patients to any great extent himself, a circumstance which certainly must be made partially responsible for our defective knowledge of this domain and for the great differences of opinion.

As far as the small series of observations, which are at my disposal allows of a judgment, the male sex appears to have a considerably larger share in paranoia than the female; almost 70 per cent. of my patients were men. They are specially in the majority, as can easily be understood, among inventors and founders of religions, while in

erotic delusions and delusions of persecution women are fairly well represented. The age at the beginning of the disease was in two-thirds of the cases above thirty, relatively most frequent between the thirtieth and fortieth year. In isolated cases the traces of the disease could be followed back to the sixteenth or eighteenth year. On the other hand I have never been able to convince myself of a really "idiopathic" origin of the delusional ideas reaching back into early childhood, as Sander had in view in classifying as a separate form his "idiopathic paranoia." Much rather in such narratives of patients it invariably concerns *pseudo-memories*. The remarkable utterances and experiences narrated with extraordinarily exact detail occur to the patient subsequently, when he examines his whole life minutely like an open book; before that they had made no impression at all upon him and were quite forgotten. Not infrequently, moreover, the cases idiopathic in this sense, belong to dementia præcox and quickly become demented; others exhibit the picture of confabulating paraphrenia.

Hereditary Relations and Psychopathic Predisposition.—I scarcely venture to say anything about the hereditary relations of the patients, not only on account of the small number of observed cases, but especially also because the information about the family history in these patients, of whom two-thirds entered the hospital first after the fortieth year, is much too uncertain. A whole series of them had led such a wandering life that one was thrown solely on their own statements, naturally very unreliable. In such circumstances I place no value at all on the fact that in rather more than one quarter of the cases psychic disease was stated to be present in one of the parents. It is perhaps more important that in more than half of the cases personal peculiarities were reported to us, which allowed us to conclude that a *psychopathic predisposition* was present. An irritable, excited, occasionally rough and violent behaviour appeared to be the most frequent. Other patients were distrustful, self-willed, superstitious, or ambitious, aspiring, unsteady, untruthful; still others were weak of will and poorly endowed. Several patients showed homosexual tendencies; some had for long suffered from nocturnal enuresis. If accordingly in the meantime there can be no talk of a uniform paranoiac predisposition, so much may yet be said that the patients

frequently exhibited from the beginning distinct personal peculiarities, which must have made the fitting into the life of a community essentially more difficult.

External occasions do not play any part at all in the history of origin, or at least only a very subordinate part. Even the unpleasant experiences now and then reported appear to me to be of significance at most for the content, but not for the origin of the delusion; often they were obviously only the consequence of morbid behaviour. The insidious development of the malady might itself give evidence for the fact that the morbid process is engendered by *internal causes*, and general opinion tends to the assumption that we have before us in paranoia an expression of *degeneration*. If we agree to this view with regard to the peculiarity of the malady and to the frequency of preparatory psychopathic features, then we find the further question in front of us, which was sharply circumscribed especially by Jaspers, whether paranoia is to be conceived as the logical development of an abnormally predisposed personality, or as a process which from a given point of time onwards brings about a morbid transformation in a hitherto healthy individual.

The former view corresponding, perhaps, more to the opinions of the French investigators, has recently been represented among ourselves especially by Mercklin and Gaupp. Mercklin speaks directly of "paranoiac germs," which are said to come later to development in the disease. In support of this opinion the multiplicity of the delusional systems could in the first place be advanced, which in spite of the return of certain fundamental features, yet lends to each individual case its wholly personal stamp. Against it may be objected that even a morbid process, which perhaps only involves certain of the highest psychic capacities, would leave wide room for the play of the influence on the clinical state of the personal peculiarities of the patient. But, further, it is perhaps worthy of notice that the various directions, which the delusions take in paranoia, correspond in general to the *common fears and hopes of the normal human being*. They, therefore, appear in a certain manner as the morbidly transformed expression of the natural emotions of the human heart. Meanwhile we find similar relations also in severe, destructive diseases of the brain, as in paralysis and dementia præcox, a sign that just the content of the delusional ideas is everywhere determined

partly by the common requirements of the *emotions*. It would, indeed, be difficult to understand whence otherwise the delusion should take its form.

But one may yet, perhaps, take up the standpoint that the connection of the delusion with personal peculiarity in paranoia is essentially more intimate than in the diseases mentioned. Without at all taking into account the fact that the million-blissfulness of the paralytic, the delusion of telepathic influence of the early dement is repeated much more uniformly, the roots of the delusion in paranoia, which appears later, can not at all infrequently be discovered in definite, preparatory features of character. The strong emotional emphasis of the experiences of life, and what is connected with that, the personal colouring of the relations to the external world in both hostile and friendly sense, appear to me very commonly to come into consideration here. Then also the feeling of personal uncertainty along with distrust plays a part and also the ambitious, passionate striving for recognition, riches, power, with measureless overrating of self. Here we have before us in a certain degree the component parts from which the development of a paranoiac view of life and the world could to some extent be explained. They carry in themselves the preliminary conditions not only for a lasting disproportion between wish and reality, but also for the influence on the whole view of life by this inward dissension. Specht has expressed the opinion that circumstances in life which bring about a conjunction of *high tension of self-consciousness with insufficient outward recognition* favour the development of paranoia; as example he mentions elementary school teachers.

If we now try to approach the question, under what premises in the one case the delusion of persecution, in the other the delusion of grandeur develops from the paranoid disposition, this might perhaps be thought of, that the original temperament, the tendency to a rosier or gloomier colouring of the experiences of life, guides the delusion formation sometimes in the one, sometimes in the other direction. If the previous history of our patients is examined minutely, a certain justification for this assumption cannot be withheld; an embittered, rancorous view of life appears indeed often to prepare for the development of the delusion of persecution, assured self-confidence for that of the delusion of grandeur.

Against such a simple assumption meanwhile the experience to some extent tells, that we find with extreme frequency both trends of delusion present *at the same time*. The attempt has usually been made to explain this conjunction by a kind of more or less clearly conscious deliberation. The patient fulfilled with ideas of grandeur is said to be forced to the assumption of hostile machinations by the resistance which he comes up against in the realization of his plans. On the other hand it may be objected that from those points of view a development of that kind might be expected invariably also in other diseases with delusions, which only happens to a rather limited extent. In any case the assumption may be defended that the struggles and difficulties in which the patient becomes involved partly by his delusions, partly on other grounds, are of considerable significance for the development of the delusion of persecution. Without taking the fact into account that in the prison psychoses we can follow with experimental directness the development of the ideas of persecution under the pressure of adverse fortune, we can also observe not infrequently that ideas of injury are added to the delusion of grandeur when the patients fall into difficult positions in life and come into collision with serious resistance.

But one may perhaps go still further and assume that in certain circumstances their insufficiency for the struggle with life arising from defective predisposition must be regarded as the root of their ideas of persecution. A man who is dominated by a secret feeling of uncertainty and sees himself hindered by his weakness in the fulfilment of his life wishes, is only too much inclined to suspect dangers and to lay the blame of his failures on external influences. Not infrequently we find that, when they have the opportunity, paranoiacs try from the outset to withdraw themselves from the serious struggles of life in the consciousness of their vulnerability; they do not take a fixed situation, but wander restlessly about, occupy themselves only with amateur occupations, and avoid contact with life.

If the incomplete equipment for the surmounting of life's difficulties and the opposition to the surroundings which results, were an essential foundation for the delusion of persecution, its incurableness could also be understood. For this disproportion continues to exist and is permanent. While in the prison psychoses the mainsprings of the

delusional formation are relaxed by the discharge of the patient to freedom, the feeling of defencelessness towards the hostile forces of life is renewed here every day. That in spite of this the delusion generally begins only in the third or fourth decade, could be explained by the gradual loss of youthful elasticity which at first compensates for every failure by the awakening of fresh hopes for the future.

It must, however, be understood that in the paranoiac formation of the delusion still a further circumstance must play a part. We come across numerous psychopaths who are not equal to the battle of life and avoid it without developing ideas of persecution. What characterizes the paranoiac is his *resistance*, his passionate struggle against the injuries of life, in which he recognizes hostile influences. Just here it is seen that the delusion forms a component part of the personality. Failures are to the patient not chance events nor are they due to his own fault, but a wrong inflicted on him, against which he opposes himself. This manner of reaction appears to me to point to the fact, that in him even when he is permanently conscious of his inward uncertainty, an *increased self-consciousness* is present at the same time; it is this which causes his special sensitiveness. If we might assume that, the frequency of exalted ideas along with the delusion of persecution could be in some measure understood.

The paranoiac delusion of grandeur has often been derived from the comprehensible estimation of the enormous sources of power which are at the command of the persecutors; in this way, it is said, the patient acquires the idea of the very special significance of his own person. That appears to me to be an artificial assumption. We should then observe similar ideas in melancholic patients, but that does not occur unless manic admixtures are present. An egocentric direction of thought cannot be straightway connected with the delusion of grandeur in any case. Against that, besides the spinning of high-flying plans of youth across into riper years, still another source of paranoiac ideas of grandeur can be imagined, which possibly arises not far from the first one.

The struggle with life may favour this direction of thought in two ways. Humiliations may rouse to defiant and exaggerated self-appreciation, which in the strongly emphasized sense of personal value creates a counterbalance to the neglect shown him by the outer world, or

else defeats and disappointments lead to submersion in a kindlier world of visions, as we have seen them do in the presenile delusion of pardon. If the delusion of grandeur in youth, full of the joy of hope, is intoxicated by its feeling of power because it does not know the seriousness of life and its resistances, the depressing experiences of life's struggle are here pushed aside because they cannot be conquered. Especially when the weapons fail, which are necessary for the conquest and subjection of the opposing hindrances, tenacity and endurance of volition, self-assertion is forced into one of these paths both of which lead to the delusion of grandeur, it may be by arrogant opposition towards the judgment of others, it may be by escape into hopes for the future which no misfortune is able to destroy.

Perhaps it will be possible some day to follow clinically the various developmental possibilities of the paranoiac delusion of grandeur. When it dominates the morbid state from youth up, we shall be able to think of its origin more from *self-complacent dreaming*. But when it develops in connection with ideas of persecution and first in riper years, it is probably more a *defensive measure against the depressing influences of life*. While the delusion in the former case betrays its history of origin in its romantic colouring, in its fund of pseudo-memories and delusional inventions, it is limited in the latter substantially to a measureless over-estimation of personal capacity. Lastly, likewise in later life, with or without connection with ideas of persecution, especially in weak-willed or otherwise insufficiently equipped natures, a delusion of grandeur may attain to development, which bears features similar to those in the first case, and which is a kind of *psychological compensation for the disappointments of life*. It must be left to the future to investigate whether these forms, in the first place derived from certain premises, can actually be found in experience; probably they will often blend with one another.

The emotional premises described above may well explain the development of delusional ideas, but not their peculiar paranoiac form. In any case by no means everyone who exhibits the peculiarities mentioned becomes paranoiac. There must be other circumstances which make the establishment and the psychic working up of the delusion possible. The surprising failure of criticism towards the emerging

delusional ideas has often been pointed out here ; it lets the patient fall a victim to their influence without making any resistance. This lack of judgment has mostly been regarded as an indication of a certain psychic weakness. In reply it must first be remarked that the delusions of the paranoiac according to the explanations just given probably have their root in *emotional tensions*, such as in normal people also usually encroach to a great extent on the capacity of forming objective judgments. As is well known, the firm persistence of political and religious convictions illustrates this ; they are not acquired, as a rule, by personal psychic work, but are inoculated by the emotional influences of education and of example, and in this way " grow round the heart " ; even in regard to such convictions purely intellectual considerations often fail in an otherwise incomprehensible way.

Meanwhile without taking into account the emotional mooring of the paranoiac delusion, certain imperfections in the intellectual functioning in our patients might also essentially contribute to lessen their capacity for resistance to the emergence and interference of delusional ideas. As it appears to me, the delusional formation of the paranoiac exhibits many noteworthy points of agreement with *undeveloped thinking*. In the first place visionary longing for impossible goals not subdued by sober deliberation, ideals as they are apparently often formed by the foundation of the paranoiac delusion of grandeur, are found in similar manner in youth. Later, with the maturing of judgment the experiences of life surely and irresistibly lead to a restriction of hope to the attainable, while in the paranoiac the conviction becomes just then firmly rooted that he is near the fulfilment of his dreams. Even the peculiarly romantic colouring of the paranoiac delusional structure, the picturing of princely and kingly magnificence, the quietly blissful, sweet secret of the erotic delusion, the tendency to day-dreaming and to the transformation of the world according to immature personal wishes remind us strongly of similar creations of the power of imagination in youth. The same holds good for the bungling of the inventors, which we find again in the clumsy but laboured attempts of our children enthusiastic for the wonders of technique.

Further, it must be pointed out that the egocentric trend of thought, the peopling of the external world with

friendly and with hostile powers, the superstitious interpretation of events, in short the whole foundation of the delusion of reference represents a common peculiarity of psychically undeveloped peoples and human beings. Dromard[1] speaks in this sense of infantile features in the thinking of the paranoiac. The more remote that thinking is from the stage of purely sensuous experience, the more conceptual general ideas are developed, all the more does the personal colouring of intellectual functioning grow pale, and all the more does judgment become objective. But, lastly, it would still need to be emphasized that also the sprouting up of fully formed convictions inaccessible to doubt is a process which we find again in the same way at the lower stages of the development of thinking. Certainty is the natural, the self-evident thing ; doubt is the bitter fruit of ripe experience.

We come, therefore, to the conclusion that a number of peculiarities adhere to paranoiac thinking which we are justified in regarding as an indication of *developmental inhibitions*. They may lead to this, that habits of thought, which otherwise are more and more overcome with the ripening of the psychic personality, here continue permanently, and with corresponding emotional predisposition gradually cause that falsification of the views of life which characterizes our disease. If one will, one might say that the world of ideas of a savage, who sees himself surrounded by demons who lie in wait for him everywhere, and perceives innumerable signs portending disaster or good fortune, or of a medicine man, who has at his command the magic powers of the fetish and produces supernatural effects by his incantations, does not fundamentally differ very much from paranoiac delusional systems. Only in the former case it concerns stages of general culture, in the latter purely personal morbid development.

It has further to be remarked that we must, of course, not regard the paranoiac simply as a grown-up child. Rather it might be assumed that in him an unsymmetrical development of the psychic personality had taken place, and so only certain domains of the psychic life had remained immature. It would accordingly concern a kind of *distortion* of the psychic picture, in which the individual features developed in various ways mutually influence and disturb each other. Thus the firm tenacity also of the

[1] Dromard, Journ. de psychologie norm. et pathol., viii. 406.

paranoiac delusional system might be explained, which at first appears to be in contradiction to the susceptibility to influence of the imaginations of youth. The playful day-dreams of the undeveloped personality are built up in a mobile psychic life, and when this matures and becomes established they lose their foundation. But in paranoia the deficiencies of intellectual functioning described continue to exist in a personality already becoming crystallized; they will, therefore, produce an essentially divergent and a more permanent effect.

Lastly, it must not be forgotten that the struggle for existence in the complicated conditions of civilization, the constant excitement due to the increased difficulties of life, must contribute to the peculiar character of the state which comes into existence under the premises described. If we, therefore, acknowledge that certain peculiarities of the paranoiac delusional formation can be derived from circumscribed developmental inhibitions and on this account exhibit points of agreement with the conduct of immature individuals and peoples, there are yet in other directions wide-spreading differences.

Peculiar disturbances of thought have been indicated by Berze[1] as the starting-point of paranoiac delusion formation. He thinks that in the paranoiacs there is a disorder of apperception which makes the grasping of psychic content in a momentary point of consciousness difficult. From this failure of "active apperception" a feeling of "suffering" is said to be developed which then probably smooths the way for the development of the delusion of persecution. The proof of these statements could scarcely be produced. On the one hand we observe that active apperception becomes difficult or ceases altogether in numerous morbid states, which are never, or only temporarily accompanied by delusion formation (mania, delirium, paralysis, idiocy); on the other hand there can be no question at all in paranoia of a general extension of the disorder named; the systematic development of the delusion here definitely presupposes the firm hold of leading trains of thought and the selective preference for definite impressions and ideas.

Summary.—If we now summarize the discussion, it must approximately be said that *heightened self-consciousness* appears to me to be an essential foundation of paranoia.

[1] Berze, Über das Primärsymptom der Paranoia. 1893.

From it proceed the high-flying plans as well as the increased sensitiveness to the difficulties of the struggle for existence, which are especially great for the psychopath. At the same time by the strong affective emphasis of the experiences of life their personal interpretation and evaluation is favoured. Thus the preliminary conditions are provided for the development of ideas of grandeur and of persecution. But that it comes to delusion formation in the paranoiac sense rests on the *insufficiency of intellectual functioning in consequence of partial developmental inhibitions*, which cause certain primitive habits of thought to continue permanently. Here belongs the tendency to day-dreaming, to an egocentric view of life, and to uncritical yielding to any ideas that occur. In accordance with this view paranoia, as is also from clinical points of view feasible, would be brought into the neighbourhood of *degeneration hysteria*, in which we are likewise concerned with the persistence in isolated psychic domains of stages of development which have been surmounted.

If we have up to now exerted ourselves to explain the points of view from which the development of paranoia from a peculiar predisposition might be made comprehensible, reasons are also not wanting which might argue for the existence of an actual morbid process transforming the personality from a definite point of time. Since tangible external causes, as a rule, are not demonstrable, maladies must be thought of which are developed from *internal* causes. With regard to the indubitable relations of paranoia to degeneration, morbid germs might come into consideration, which were already present in the disposition, but only later develop in an independent manner, as in certain familial diseases of nerves, for example, Huntington's chorea. Of significance for this question is, firstly, the circumstance, that the roots of the paranoiac delusion can by no means always be traced back to a distant past; the ideas often appear rather abruptly, at least according to the representations of the patients. Here it must certainly be taken into account that invariably the patients only come under our observation many years after the commencement of the malady, and that their statements very commonly are more or less strongly influenced by pseudo-memories.

Further, for the assumption of a morbid process the course in exacerbations which is seen fairly often, might be mentioned, the crowding together of delusion formation

in relatively short periods of time with intervals lasting for years. It is evident that this argument would only have significance if the paranoiac development of the personality assumed above were conceived as wholly independent of external influences. But if one acknowledges, as we did, that for the coming into being of the paranoiac delusion the struggle with life is of authoritative significance, a course in exacerbations might very well result from external influences. Unfortunately up to now no adequate investigations of this question are to hand; they might also come into collision with almost insuperable difficulties. It must, however, be said that in the development of a personality, probably also from internal causes, at any time more rapid transformations and likewise intervals may be interpolated; the experiences of normal life seem to give evidence for this.

The circumstance is very noteworthy, that the content of the delusional ideas is sometimes extraordinarily far removed from normal thinking. It, therefore, is at first difficult to assume here a simple development from the normal latitude. Some evidence for our judgment may perhaps be got from the prison psychoses, in which we see very similar delusions, which in certain circumstances never again disappear, developing under the pressure of psychic injuries. Accordingly the possibility cannot be denied that a paranoiac delusion in spite of its senselessness may come into being solely through unfavourable emotional influences. Certainly we must here in all circumstances premise a well-marked paranoiac predisposition, since we are not concerned, as among the prisoners, with unusual fortunes in life, but with the effect of the everyday difficulties of the struggle for existence, which only here are felt as specially oppressive.

We come, therefore, to the conclusion, that at present definite evidence for the assumption of a morbid process as the cause of paranoia cannot be found, but that we have to reckon with morbid preliminary conditions in the form of quite definite insufficiencies of the predisposition. In so far points of contact with the view last discussed would be present. Only it would not concern the continued development of morbid germs to independent morbid processes reaching into the psychic life, destroying and distorting, but the natural transformations to which a psychic malformation is subjected under the influence of the stimuli of life.

It would have been impossible for the Freudian doctrines not to have taken possession of the question of paranoia. According to the results of psycho-analysis auto-eroticism, narcism, homo-sexuality, form the starting-point of paranoia. The disease sets up the defensive symptom of distrust towards others in order to overcome the unconsciously reinforced homo-sexuality. The delusional formation is in reality an attempt at cure after the catastrophe. Since these assertions are not supported either by a clearly defined conception of paranoia or by evidence at all acceptable, it might be unnecessary to occupy oneself further with them.

CHAPTER VI.

DELIMITATION.

THE delimitation of paranoia is not less difficult than the search into its character. We have already in the introduction mentioned the changes which the extent of the conception of paranoia has gone through in the course of the last decades. If dementia paranoides, the paraphrenias, and a series of other paranoid diseases are kept apart, as has been done here, there remain still two directions in which there are important questions of delimitation to solve. In one it concerns the decision whether there are *curable forms of paranoia running an abortive course*. Certainly now we shall no longer be able to agree with the view of Westphal, who in his time regarded cases of compulsion insanity as abortive paranoia, but it remains still to investigate whether paranoiac delusion formation must continue permanently in all circumstances. The French have described "bouffées délirantes", which they are inclined to place in relation to paranoiac diseases, and among ourselves also one speaks of delusion formations in degenerates, for which according to their history of origin a relationship with those of the paranoiacs would probably have to be acknowledged. With reference to the assumption made by Wernicke of an "idea of over-estimation," which may for a longer or shorter time dominate the patient, Friedmann has, as was mentioned above, published observations about "mild delusional forms." Here in immediate connection with external events agitating the emotions (disappointed hopes of marriage), a systematized but circumscribed delusion appeared, namely, the *delusion of respect*, which gradually faded again after two or three years without any exact rectification; it concerned mostly women thirty or forty years of age. Lastly, Gaupp has mentioned cases of educated men with "depressive-paranoid" predisposition, in whom under the pressure of painful circumstances a distrustful delusion of reference with a certain amount of insight and fluctuating course insidiously developed without leading to rigid systematization.

It is not easy to take up a position in relation to all these experiences. One of the principal difficulties at present is, in my opinion, *diagnostics*. I have, namely, convinced myself that there are cases of *manic-depressive insanity*, which on account of the many delusional ideas which appear and the inconspicuous colouring of the background of mood, may with extreme ease be taken for abortive cases of paranoia. In spite of attention specially directed to this point it has happened to myself till quite recently, that I have regarded such attacks as paranoiac exacerbations. The possibility will, therefore, always have to be reckoned with that one or other case of paranoid disease having a favourable course, although without acquiring full morbid insight, must be interpreted in the sense mentioned. We shall have to come back to this question.

The delusion formations of the *degenerate* are, so far as is known at present, invariably of *psychogenic* origin and are connected with a *definite, tangible occasion*, as far as they at all exhibit a certain similarity with paranoia. In this point they thus differ throughout from the insidious development of paranoiac delusion formation. It appears to me, therefore, suitable to separate them from it. But it will have to be admitted, that there may be transitions here, according to whether a larger or smaller rôle falls to the personal peculiarity on the one hand, to the external obstacles on the other, in the history of origin of the morbid phenomena. Paranoia and psychogenic delusion formation may, perhaps, be regarded as the end-links in a chain in which all possible intervening links are represented.

From this standpoint no objection could on principle be raised against the occurrence of "*mild*," *psychogenic forms of paranoia* resulting in *cure*. It would only have to be assumed that here a "latent" paranoia exists permanently, which not in all circumstances, but only on special occasions leads to delusion formation. Thus it would also be comprehensible that the delusion formation would again come to a standstill, when the occasion was removed or its effects counter-blaanced. Any other event in life might then later in a similar way cause the disease. We should thus be concerned more with the permanent *tendency* to delusion formation, with isolated attacks of delusion, not, as in developed paranoia, with an inexorably progressive delusional transformation of all the views of life in a definite direction.

It cannot be said at present with certainty, whether and how far the views here developed can be brought into agreement with clinical experiences. In any case it appears to me that there are predispositions, which, indeed, carry in themselves the germ of continued development in a paranoiac direction, but only develop it further to a transitory and indistinct delusion formation. Mercklin speaks of personalities which throughout their whole life are on the way to paranoia. Even among the more pronounced cases of paranoia, many are found in which the system of delusions exhibits a less rigid and closed form than it is customary to assume from an academic point of view. Among the psychopaths who resort to our hospital I have come across a certain number of personalities, certainly not very large, whom I might call "paranoid," in as far as they appeared to me to exhibit essential preliminary conditions for the development of paranoia; some of them even displayed the rudiments of it, yet without an actual delusional system attaining to development. I shall try, as far as the limited experiences at my disposal allow, to give a short description of this group of paranoid personalities.

Paranoid Personalities.—In the majority of the patients *ideas of persecution* were in the foreground of the clinical picture, probably because they most frequently give occasion for a consultation with the alienist. The most conspicuously common feature was the feeling of uncertainty and of distrust towards the surroundings, which expresses itself in the most varied forms. The patient feels himself on every occasion unjustly treated, the object of hostility, interfered with, oppressed. His own people treat him badly; his fellow-workmen do not like him; they teaze him, make remarks about him, look at him derisively as at some one mentally unsound, laugh at him. Everything presses on him; he has to endure a martyrdom, he complains about his "life crushed and trodden on". A patient spoke of "pecuniary ill-usage continued for years", when his guardian in consideration of his small means was not able to satisfy all his excessive financial claims. People want to drive him from his situation; the foreman aims at him. In indefinite hints he speaks of secret connections, of the agitation of certain people. Things are not as they ought to be; everywhere he scents interested motives, embezzlement, intrigues; the wire-pullers of the injuries

from which he suffers are known to him, but he will not speak out. One patient could read off the faces of people the evil in them. The physicians whose duty it is to examine him, give a prejudiced opinion; the authorities show partiality. A patient, who thought that his wife had put the virus of gonorrhœa in the soup, asserted that the police did not wish to have the affair investigated, because he had no money to pay. Another complained that he had been wrongfully declared to be mentally unsound, while the verdict had been pronounced in favour of his mental health. Some patients expressed ideas of jealousy; one patient noticed that his wife did not concern herself about him; she showed him by her behaviour to others "that she was perhaps unfaithful to him." He wanted to get rid of her, but when she was gone, he had a great longing for her, and then when she returned, he immediately recommenced the old reproaches.

Such delusional ideas, which emerge sometimes on one occasion, sometimes on another, are closely accompanied by great *emotional irritability* and a *discontented, dejected mood*. The patient is difficult to get on with, is fault-finding, makes difficulties everywhere, perpetually lives at variance with his fellow-workers, on trivial occasions falls into measureless excitement, scolds, blusters, and swears. He composes long-winded documents full of complaints, threatens his wife, ill-uses the children, applies for a divorce, speaks of shooting the foreman. Others withdraw themselves, refuse to have anything to do with the people round them. One patient communicated with his wife in writing only; another obstinately refused to obey judicial summons.

The patients have no understanding for the insufficiencies of their personality, which appear in their whole conduct. They are impatient and obstinate, think that they are perfectly within their rights, that their unusual actions are quite in order, hold firmly and stubbornly to their ideas. On the other hand they are often extremely credulous in regard to communications, which lie in the direction of their thoughts; they accept without hesitation every piece of gossip as truth, let themselves be imposed upon, get into scrapes.

As a rule, heightened self-consciousness can be easily demonstrated. The patients boast of their performances, consider themselves superior to their surroundings, make special claims, lay the blame for their failures solely on

external hindrances, without which they would undoubtedly have been in a position " to do useful and beneficial work ". I have also come across a few cases which might be regarded as in the initial stages of the *paranoiac delusion of grandeur* in its various forms. I saw some inventors who occupied themselves with perpetual motion, and hoped by their future successes to gain money and honour on a considerable scale ; one of them expected great things from savings-bank stamps with business advertisements. Other patients were conspicuous by their high-flying plans and ideas for benefitting the world, which were quite out of proportion to their knowledge and ability. They thought of themselves as having a mission which they had to fulfil, although they were not able to meet the most commonplace claims of life. I have also met indications of erotic delusion, patients, who in spite of the most unequivocal refusal, yet ever again pursued the supposed beloved and tried by entreaties and threats to make her yield.

Intellectual endowment was on the average fairly good in the patients discussed here ; all the more striking was the failure of judgment in regard to their delusional ideas. Capricious behaviour with frequent change of mood was often observed, the influence of which could also be recognized in a restless, adventurous conduct of life. Occasionally there were hypochondriacal complaints, twinges of pain in the back, constriction in the breast. Several times great sexual excitability was reported. Some patients made suicidal attempts, occasionally repeated. In isolated cases hysterical disorders appeared, convulsive weeping, fainting fits, diminution of the pharyngeal reflex, concentric restriction of the field of vision. Many patients at times took excessive alcohol. Almost all lived permanently in freedom, mostly without any special difficulty ; they were only on some special occasion once in a while brought temporarily to the hospital.

What distinguished the delusions of these patients from those of pronounced paranoia was their *vagueness* and the *absence of systematic working up*. Their fears and hopes were of a more indefinite kind, were brought forward as indications and conjectures, or they consisted in a strong personal valuation of actual events, which was not too far removed from the one-sidedness of normal individuals. As far as could be known, no internal connection of the individual component parts of the delusion with a paranoiac

view of life had taken place. They did not appear to have actually passed into the flesh and blood of the patients ; they appeared and receded again, yet without quite vanishing. It may naturally be objected that the patients, perhaps, kept their innermost trains of thought secret, or that the development of a delusional system will still take place later. Further experience must decide about these possibilities. At present the assumption appears to me to be well founded, that cases of undeveloped, " rudimentary " paranoia would not only fit in with our view of the character of the disease, but also come actually under observation.

It will certainly be often doubtful in the individual case whether and when we are right in calling a morbid personality, in the sense here delimited, " paranoid." It seems to me to be essentially a *combination of uncertainty with excessive valuation of self*, which leads to the patient being forced into hostile opposition to the influences of the struggle for life and his seeking to withdraw himself from them by inward exaltation. Further, a strong personal colouring of thought by vivid feeling-tones, activity of the power of imagination and self-confidence, might be of significance. If these peculiarities lead to isolated or general delusions without systematization, the paranoid psychopath would with that be approximately characterized.

The great restriction which the conception of paranoia has suffered in the course of the last few decades, frequently led to the prophecy, that it would soon wholly disappear. Indeed, Specht has made the attempt to solve the whole morbid state of paranoia. He thought that querulant delusion first, but then next paranoia contained in itself " the whole inventory of mania," the pressure of talk and writing, the restlessness, the digression, the readiness of repartee. For him accordingly the disease only signifies the reaction of a *manic-depressive predisposition* to an event which excites emotion. It must be admitted that some of the features mentioned are now and then found in paranoiacs, further, that there are manic patients with abundant delusions mentally worked up, who on account of the slightness of their excitement may for a considerable time be held to be paranoiacs. On the other hand the view of Specht appears to me to shoot far beyond the mark. There are numerous paranoiacs in whom the peculiarities resembling those of manic patients are altogether absent.

But when they are present, they invariably have a history of origin and a significance quite different from the similar manic phenomena. Pressure of speech and writing are explained by the active endeavour to defend themselves against persecution or to advance their own high claims, restlessness by the incapacity for persevering, useful work in consequence of the delusional disorders, digression by the heightened activity of the power of imagination, readiness of repartee by increased self-consciousness and by the mental working up of the content of the delusions, which has long ago solved all difficulties, although often in an extremely inadequate manner.

CHAPTER VII.

DIAGNOSIS AND TREATMENT.

THE diagnosis of paranoia presents scarcely any difficulties to attentive consideration of the slow development, of the peculiar, connected delusion formation, of the excellent preservation of intelligence as well as order in the train of thought, in conduct, and in activity. Certainly there are a number of diseases which may temporarily exhibit a similar picture. The delimitation of the malady from the "paranoid" mental disorders we have already considered. That there can be no question of transitions between paranoia in the sense here delimited and dementia præcox, as has been assumed by some observers, needs no special discussion.

Schizophrenia.—On the other hand at this point the possibility must shortly be discussed, that many cases of apparent paranoia might really be imperfectly developed schizophrenias. In the individual case it is not always easy to decide this question. The delusional system of the paranoiac is internally more closed, more rounded off, more thought out; it takes account up to a certain degree of objections, tries to explain difficulties, in contrast to the abrupt delusional ideas of the paranoid schizophrenics, which are often contradictory to each other and also change frequently. In the latter, moreover, the signs of emotional devastation will not be missed, the slight internal interest not only in the surroundings, but also in the delusion, which at most leads to occasional outbursts, but provides no permanent motives for activity. In the paranoiac also we meet now and then a reserved, repellent manner, and peculiarities of many kinds in the conduct of life. But his conduct is invariably far more grounded on deliberation or emotional processes than the impulsive peculiarities of the schizophrenic. The whole personality in spite of its morbid features appears more comprehensible, more natural, more susceptible to influence. It is much easier by intelligent treatment to come into inner relations with it than with the capricious, inaccessible schizophrenic.

Schneider has described a case, which I consider a genuine paranoia, as a paranoid terminal state of dementia præcox, as I believe, without sufficient foundation.

Paraphrenia.[1]—We have further still to discuss the distinction of paranoia from the paraphrenic diseases, especially from the *systematic* form. In the first periods of the malady the similarity of the clinical states is so great that it will be very difficult to keep them separate. The circumstance seems to me to be of significance, that in paranoia exalted self-consciousness appears more distinctly from the outset; if the delusion of grandeur dominates the morbid state from the beginning or at least very soon, it is probably a case of paranoia. With this difference the fact is, perhaps, also connected, that the paranoiac is usually not nearly so much tormented by his ideas of persecution, and also not so much influenced in his actions as the paraphrenic patient. The latter proceeds far more regardlessly against his supposed persecutors, soon has resource to self-help and with all means in his power, so that invariably he comes to the institution comparatively early and often has even to be kept there permanently. At the same time he carries on the struggle with the greatest acrimony. In contrast to that the paranoiac possesses far more self-control, restricts himself to legal methods of fighting, yields to obvious supremacy, and understands how to avoid permanent deprivation of freedom by circumspect behaviour and concession. The compulsion of the morbid change by no means subjugates the personality to the same extent as in paraphrenia. Moreover, we have before us in the latter disease a constantly, although slowly progressive course, while the paranoiac may exhibit for decades a fairly uniform state, and often learns also to come to an agreement, practically endurable, with the difficulties resulting from his delusion. Besides that the delusion in paraphrenia gradually becomes always more extraordinary; hallucinations and exuberant ideas of grandeur are added, and the patients in their whole conduct are seen to be so strongly dominated by the morbid phenomena that they now can scarcely any longer be confused with the orderly and sociable paranoiacs who mostly are even able to earn their living.

Many cases of the "délire d'imagination" or "rétrospectif," which by the French are taken together with

[1] *Dementia Præcox and Paraphrenia*, p. 283.

"délire d'interprétation," our paranoia, probably belong to *confabulating* paraphrenia. In it the extraordinary abundance of pseudo-memories is noteworthy; they serve by no means only for the development of a definite delusion as in paranoia, but they bring to light all possible trifles frequently of no importance at all. The delusional interpretation, conjectures, and presentiments which are always in the foreground in paranoia and are only supplemented and confirmed by pseudo-memories, go quite into the background here behind the regardless confabulation. The development of the malady is usually accomplished with considerably more rapidity than in paranoia; at the same time the indications of psychic weakness, striking lack of judgment, emotional dulness, incoherence, for the most part appear fairly soon in an unmistakable manner.

Manic-Depressive Insanity.—Essential difficulties may, as Lähr[1] among others has shown, occasionally arise in distinguishing paranoia from delusional states of manic-depressive insanity, as just attacks of that kind occasionally exhibit a very "extended" course and comparatively few conspicuous emotional disorders. To this there may be added discharge by an external occasion, alternation or mixture of morbid phenomena of various kinds and tardy recovery without genuine insight. As to detail, it must be remarked that in the forms with depressive colouring more exact observation can still distinctly recognize the permanently depressed or anxious mood, which characterizes states of that kind. In contrast to that the paranoiac appears in general less constrained emotionally; he only becomes irritated and embittered, when he is telling of the wrongs done to him. Abrupt fluctuations of mood, especially a sudden outburst of jocularity, pleasure in enterprise, indications of flight of ideas, likewise the appearance of ideas of sin, hopelessness, despair, give evidence for manic-depressive insanity.

Hypomania.—In hypomanic patients one will have specially to take into account their volitional restlessness, which is ever going after new plans in contrast to the steady, uniform pursuit of a definite aim by the paranoiac. Further, the demonstration of heightened distractibility and susceptibility to influence from the surroundings is of significance. The delusion formation mostly betrays a playful, bragging character, and also probably changes its content, while the

[1] Lähr, Schweizerhof, 3, Bericht, 59, 1903.

paranoiac, true to his convictions, holds fast to the same ideas once they are developed. Lastly, the manic mood inclining to outbursts of anger or to self-derision is characteristic, and essentially different from the dignified reserve or the naive confidence of the paranoiac.

For the assumption of manic-depressive insanity, independent of the colouring of the actual clinical picture, the fact that other attacks with a favourable course have preceded is of great weight. On the other hand the absence of other attacks before and after cannot be made use of for the diagnosis of paranoia, even when the history of the patient is followed, as Thomsen has done, for many years. We have, indeed, already seen that the free intervals in manic-depressive insanity may extend over three or four decades, but above all that well-characterized cases with only one attack in a lifetime are by no means rarities. That is also the reason, why I, with Kleist, must very decidedly call in question the cured " acute " forms of paranoia, in so far as they do not come under the heading of " abortive " paranoia described above.

Liars and Swindlers.—With the paranoid personalities, so far as they exhibit ideas of grandeur, morbid liars and swindlers may have a certain external similarity. Only in the latter it concerns not genuine delusions, but " delusional imaginations ", sudden fancies, which are brought forward more in a playful manner, and come and go without acquiring any authoritative influence on the internal aspect of the personality. The content of these inventions is usually far more variegated and extraordinary than the monotonous delusions of the paranoiac, which conform more to the actual circumstances of life. With regard to the wrongful claimants to thrones, claimants to money, and benefactors of the people, the question will occasionally emerge, how far it concerns paranoiacs or conscious swindlers. The circumstance is here decisive, whether the individuals in question themselves believe in the justice of their claims or in their mission. It can usually be ascertained by somewhat long observation whether they utilize their proceedings solely for the attainment of selfish ends, or whether the matter itself really lies next their heart, whether they also hold fast to it when they get nothing but suffering from it.

Treatment.—There can be no question of real treatment of the paranoiac in the nature of the case. Of course, one may hope that a life without any specially strong

emotional stresses or strains, protected from excesses, and filled with well-regulated activity, may contribute to prevent the development of the slumbering paranoiac germs, and make exacerbations of the malady, which might appear, run an abortive course. The cure of a pronounced paranoia by direct psychic influence could probably be expected only by a psycho-analyst. Bjerre has published a case of that kind, in which he, certainly without actual psycho-analysis, but by a kind of cautious art of persuasion, cured a delusion of persecution which had existed more than a decade. Unfortunately the diagnosis of paranoia admits of grave doubts. Thus we shall in the meantime have to restrict ourselves to keeping our patients by distraction and occupation as much as possible from being absorbed in their delusional ideas. That frequently succeeds, in favourable circumstances for decades, so well, that the patients in spite of the most marked delusions are yet capable of living without too great difficulty in freedom. Every effort will, therefore, be made to save them, as far as it can at all be done, from seclusion in an institution.

INDEX

MANIC-DEPRESSIVE INSANITY

PARANOIA